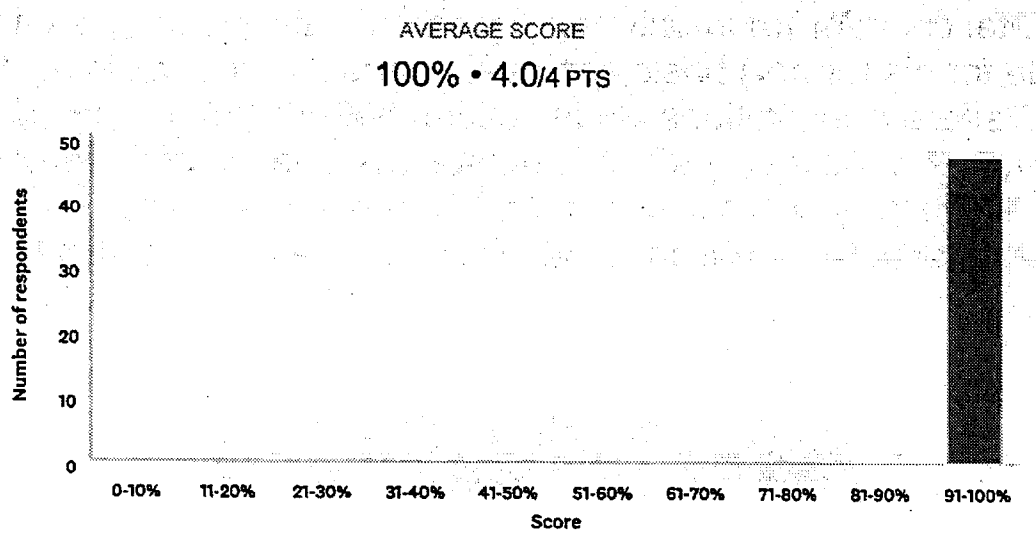
Quiz Summary



STATISTICS

Lowest Score	Median	Highest Score
100%	100%	100%

Mean: 100%

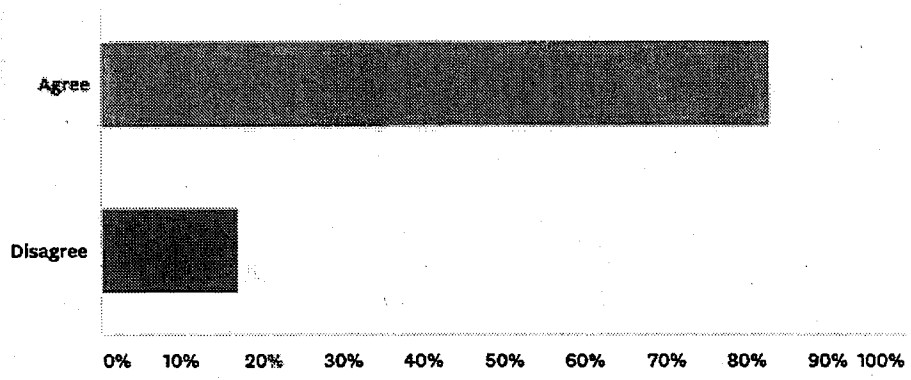
Standard Deviation: 0%

Question Ranking

QUESTIONS (4)	DIFFICULTY	AVERAGE SCORE
Q1 Current Definition: A condition in which a person, as a result of a mental disorder (or impairment by chronic alcoholism), is unable to provide for his (or her) basic personal needs for food, clothing or shelter. (Welfare & Institutions Code section 5008(h)(l)(A),(2))Proposed Definition: A condition in which a person, as a result of a mental disorder (or impairment by chronic alcoholism), is unable to provide for his (or her) basic personal needs for food, clothing, shelter or medical needs.	1	100%
Q2 Assessment of physical health needs under the proposed definition must be conducted by a licensed physician over a meaningful course of monitoring and attempting to engage in treatment.	1	100%
Q4 The physical health condition must be such that the individual is not capable of safely surviving in freedom with the help of willing and responsible family members, friends or third parties.	1	100%
Q3 The nature of the individual's physical health need(s) must be visibly apparent, progressing, and at predictable risk of becoming life/limb threatening.	1	100%

Q1 Current Definition: A condition in which a person, as a result of a mental disorder (or impairment by chronic alcoholism), is unable to provide for his (or her) basic personal needs for food, clothing or shelter. (Welfare & Institutions Code section 5008(h)(l)(A),(2))Proposed Definition: A condition in which a person, as a result of a mental disorder (or impairment by chronic alcoholism), is unable to provide for his (or her) basic personal needs for food, clothing, shelter or medical needs.

Answered: 47 Skipped: 0



QUIZ STATISTICS

Percent Correct	Average Score	Standard Deviation	Difficulty
100%	1.0/1.0 (100%)	0.00	1/4

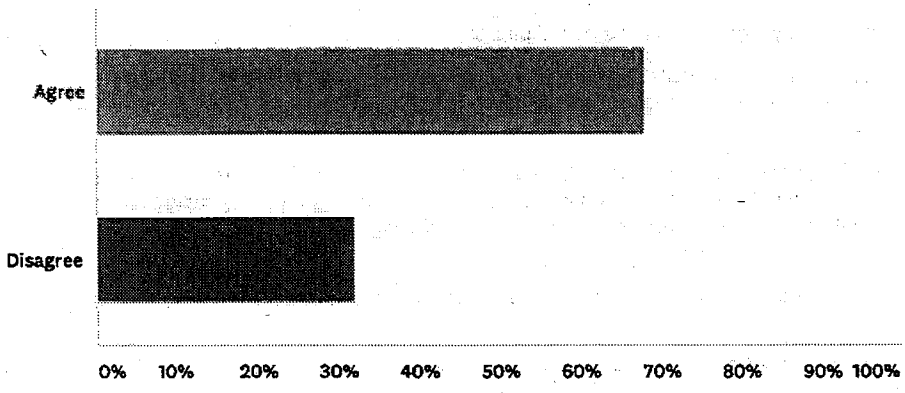
ANSWER CHOICES	SCORE	RESPONSES	
✓ Agree	1/1	82.98%	39
✓ Disagree	1/1	17.02%	8
TOTAL			47

#	COMMENT:	DATE
1	too broad, also where and how would all these folks be cared for with the serious shortage of facilites?	12/15/2017 5:53 PM
2	California policy is currently that "autonomy is king" with medical decisions. People are free to make their own medical decisions, even if their medical decisions are illogical or dangerous. We therefore should not be locking up people for making poor medical decisions – other California statutes and policies would need to be changed first.	12/7/2017 4:40 PM
3	Attending to medical needs of the severity necessary to meet the proposed standards would require the consent of the individual. If they are not consenting to the offering of care at this stage, what makes you think you will be able to secure their consent for medical procedures? Or, are you suggesting that placing someone on a LPS hold would negate the requirement that the person on the hold would have to consent to medical procedures - that would be a scary proposition.	12/7/2017 1:30 PM
4	This runs the risk of being used (even more than it already is now) to detain individuals who disagree with the doctor's proposed course of medical treatment, effectively turning a psychiatric hold into a medical hold, and further reducing the freedom of individuals (especially those with a psychiatric diagnosis) to self-determine their own medical care.	12/6/2017 7:38 PM

5	The exclusion of medical needs in this definition makes no sense. Critically needed.	12/6/2017 1:28 PM
6	Most mentally ill homeless have no idea how ill they are and to what degree they need medical attention.	12/5/2017 7:40 PM
7	If all above are so would medical!	12/5/2017 5:32 PM
8	There should have been an option for "Not Sure." There are far too many questions regarding implementation and funding to give an answer.	12/4/2017 3:41 PM
9	I am hesitant to continue including alcoholism as there is no way to mandate someone to SUD tx	12/4/2017 1:36 PM
10	this may include a very large additional group of people	12/4/2017 1:34 PM
11	This makes sense as long as mental health departments are made responsible for ensuring that the person receives the needed medical care, thereby expanding the scope of services provided by mental health.	12/1/2017 6:34 PM
12	this would help us provide care for people who are generally able to care for themselves, but are delusional about their eating disorder, need for cancer treatment, or other serious health risks -- with mental health treatment the delusion beliefs could be properly dealt with and the person would then likely consent to care.	12/1/2017 2:02 PM
13	Lack of insight into the need to get medical care seems to be a large contributor to early death in consumers with SMI.	11/30/2017 2:05 PM
14	Could it say physical and/or mental health needs? Perhaps medical needs?	11/29/2017 10:44 PM

Q2 Assessment of physical health needs under the proposed definition must be conducted by a licensed physician over a meaningful course of monitoring and attempting to engage in treatment.

Answered: 47 Skipped: 0



QUIZ STATISTICS

Percent Correct	Average Score	Standard Deviation	Difficulty
100%	1.0/1.0 (100%)	0.00	1/4

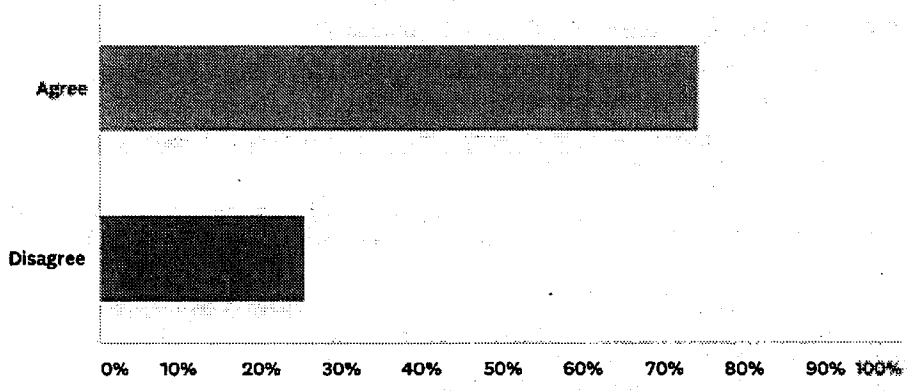
ANSWER CHOICES	SCORE	RESPONSES	
✓ Agree	1/1	68.09%	32
✓ Disagree	1/1	31.91%	15
TOTAL			**47**

#	COMMENT:	DATE
1	too intrusive in peoples rights with the fear this could venture into every private citizens lives,,, too much government in peoples lives	12/15/2017 5:53 PM
2	Doesn't seem practical - physicians won't go where they need to be.	12/7/2017 1:30 PM
3	I do not agree or disagree. This is too broad. See above for concerns about how this proposed definition would be used.	12/6/2017 7:38 PM
4	The "attempt to engage in treatment" is only valid if there are a range of choices for the individual so that the burden of engaging is placed on system of care to offer true alternatives.	12/6/2017 6:02 PM
5	I might be challenging for a licensed physician to conduct in timely fashion in all locations so suggest expanding to NP's and possibly RN's.	12/6/2017 1:28 PM
6	Other trained and educated health care professionals can make those assessments.	12/6/2017 9:29 AM
7	To get a clear understanding of actual needs globally	12/5/2017 5:32 PM
8	What about FNP's, for example working under a Physician license?	12/5/2017 12:11 PM
9	This language is ambiguous. Definition of "meaningful"?	12/5/2017 10:39 AM

10	Currently the LPS Act is mostly silent on the issue of medical consent for physical health care. When there is a need for intrusive medical treatment a separate court order is necessary. Will being gravely disabled lead to a finding that the person lacks the ability to give informed consent for physical health? On a one time basis or are we looking for that to be the finding for the entire conservatorship? Will the process be similar to the Probate Conservatorship process and a general finding that the conservatee lacks consent based on a capacity declaration?	12/4/2017 3:41 PM
11	*under reasonable circumstances	12/4/2017 3:20 PM
12	Would be needed if change was made	12/4/2017 1:34 PM
13	Needs to state Nurse Practitioners or other qualified medical professional.	12/2/2017 2:19 PM
14	May be difficult to determine over a course and the needs are more imminent. Also, sometimes a physical health need can be assessed by a non physician clinician.	12/1/2017 7:28 PM
15	do you want to include NP's and PA's here? (I'm thinking of rural areas and skilled nursing facilities where allied health providers are primary care providers)	12/1/2017 2:02 PM
16	Physical health needs are often obvious to a clinician, case manager, LPT, NP, PA who could also report the physical health need and the consumer's inability to understand or consent to medical treatment.	11/30/2017 2:05 PM
17	"meaningful course" implies multiple visits/encounters with a patient. this needs to be more clearly defined. Think of an emergency room doctor needing to treat an actively psycotic patient refusing treatment for a life saving physical ailment (lets say sepsis from a foot wound) because they feel the doctor works for the FBI and is implanting a tracking device.	11/30/2017 10:42 AM
18	Proposed language eliminates possibility of care by nurse practitioner or other professional. "Meaningful course of monitoring and attempting to engage in treatment" is too vague and could be interpreted to require too long a time period to meet. Many patients may need care sooner.	11/30/2017 4:02 AM
19	In order for this assessment to occur wouldn't it require some form of institutionalization or hospitalization? What if the person is simply homeless, but hasn't committed any offense are we proposing to forcibly detain them?	11/29/2017 9:10 PM

Q3 The nature of the individual's physical health need(s) must be visibly apparent, progressing, and at predictable risk of becoming life/limb threatening.

Answered: 47 Skipped: 0



QUIZ STATISTICS

Percent Correct	Average Score	Standard Deviation	Difficulty
100%	1.0/1.0 (100%)	0.00	1/4

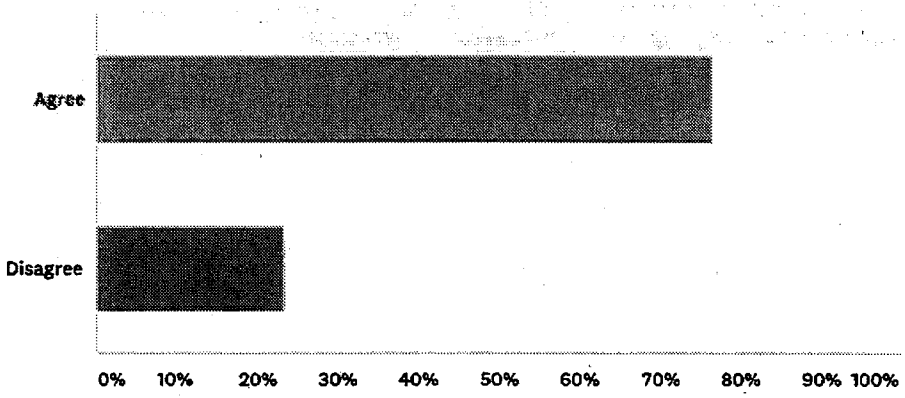
ANSWER CHOICES	SCORE	RESPONSES	
✓ Agree	1/1	74.47%	35
✓ Disagree	1/1	25.53%	12
TOTAL			**47**

#	COMMENT:	DATE
1	depends on the beneficiary and their beliefs, not the physician or evaluator.	12/15/2017 5:53 PM
2	Not sure if an tool is needed for standardization - may be too vague	12/8/2017 5:13 PM
3	"Visibly apparent" seems too restricting. For example, atrial fibrillation is invisible but has a "predictable risk" of being life threatening. Also, "predictable risk" is quite vague. Uncontrolled diabetes has a predictable risk of causing amputation, but it could take decades to do so.	12/7/2017 4:40 PM
4	I disagree with the expansion of LPS criteria. The means already exist through LPS under LPS conservatorship - a better course of action would be to adequately fund the Public Guardian's office.	12/7/2017 1:30 PM
5	"Predictable risk" is too vague, and will encourage physicians to speculate/extrapolate otherwise non-emergent situations to fit this new definition. Suggest "imminent risk" instead of "predictable risk." (See above for concerns about how this proposed definition would be used.)	12/6/2017 7:38 PM
6	Why only visibly apparent? That would exclude many (likely most) life threatening conditions.	12/6/2017 1:28 PM
7	Not always visible!	12/5/2017 5:32 PM
8	I worry about the interpretation of visibly apparent. I think that could be omitted.	12/5/2017 11:26 AM
9	Not all physical health needs are visible.	12/2/2017 2:19 PM
10	This sounds good, but is it too vague? How do you define "progressing" if you don't know the person? That is, can you determine "grave disability" without knowing a history?	12/1/2017 6:22 PM

11	brain cancer isn't visibly apparent, and neither are some other physical health needs, so I might want to remove the word "visibly" -- not sure why that is needed.	12/1/2017 2:02 PM
12	I would say "and/or" because not all are visible to the eye but may be known about such as untreated cancer.	11/30/2017 2:05 PM
13	"visibly apparent" implies can been seen - what about lab results - again lets says sepsis or a toxic lab value. needs to be better defined	11/30/2017 10:42 AM
14	Why "visibly apparent?" Diabetes, high blood pressure, and myriad other conditions that definitely require treatment are not visibly apparent. In addition, a condition may be very serious and damaging without "progressing" - why be forced to wait until it progresses.	11/30/2017 4:02 AM

Q4 The physical health condition must be such that the individual is not capable of safely surviving in freedom with the help of willing and responsible family members, friends or third parties.

Answered: 47 Skipped: 0



QUIZ STATISTICS

Percent Correct	Average Score	Standard Deviation	Difficulty
100%	1.0/1.0 (100%)	0.00	1/4

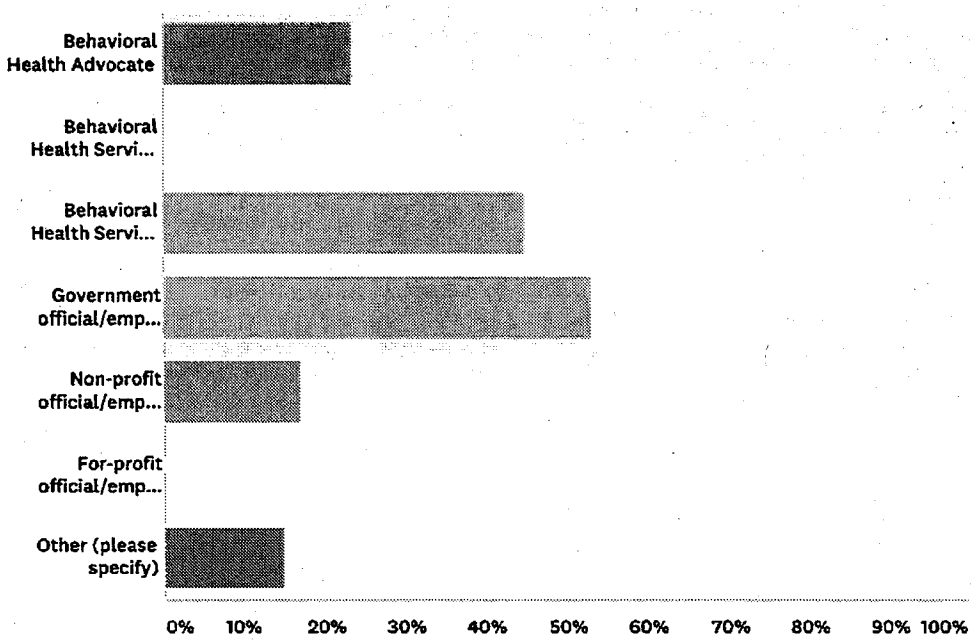
ANSWER CHOICES	SCORE	RESPONSES	
✓ Agree	1/1	76.60%	36
✓ Disagree	1/1	23.40%	11
TOTAL			**47**

#	COMMENT:	DATE
1	too much power in providers hands..	12/15/2017 5:53 PM
2	Too broad even though intent is good. Hard to measure.	12/8/2017 5:13 PM
3	I disagree with the expansion of LPS criteria. The means already exist through LPS under LPS conservatorship - a better course of action would be to adequately fund the Public Guardian's office.	12/7/2017 1:30 PM
4	This wording at least limits the proposed definition to situations where survival is at stake. Better, but still capable of overly-broad interpretation. A nexus between the mental disorder and the specific decision(s) surrounding the physical health condition should be required.	12/6/2017 7:38 PM
5	I am concerned about the subjectivity of this judgment. The availability of relevant service, support system assistance has a lot to do with whether an individual is perceived as capable of "surviving in freedom."	12/6/2017 6:02 PM
6	Except with the word "freedom "	12/5/2017 5:32 PM
7	Change "in freedom" to "independently".	12/5/2017 10:39 AM
8	I don't understand this statement	12/4/2017 6:19 PM
9	I disagree with the comment of safely surviving in "freedom." The Welfare and Institutions code allows for the release of an involuntary patient if they can survive safely but does not put it in the context of a person's constitutional right to self determination or the rights to be in the least restrictive environment which may mean an open setting. I find the reference to freedom concerning as we should not be considering grave disability in the context of a person's freedom.	12/4/2017 3:41 PM

10	I think the bolded section isn't clear in terms of intent? safely surviving in freedom...not clear.	12/4/2017 1:36 PM
11	Agree, although confusing here I feel (may be I am reading it incorrectly). It is usually that a person is not capable of safely surviving in freedom without the help, but would be, with the help of someone (provider, friend), and the goal is then to get the person urgently connected and all. But, yes, also there are times that with the help of willing person, it is not enough and the person is still in need of support for safely surviving due to the health condition.	12/1/2017 7:28 PM
12	The greatest concern is where to place these individuals. We have had clients with severe and chronic physical health disabilities that could not be placed anywhere because the available facilities did not have the ability to deal with both physical health and mental health conditions.	12/1/2017 6:34 PM
13	"in freedom" makes it sound like we're hoping to jail people. I don't like this and don't see why it is relevant. Health decisions are not left to family, friends or third parties and I think this takes the discussion in the wrong direction.	12/1/2017 2:02 PM
14	I'm a little unsure of this meaning.	11/30/2017 2:05 PM
15	not sure you need "in freedom"	11/30/2017 10:42 AM
16	Every individual is capable of safely surviving in freedom with the help of willing and able responsible family, friends, or third parties. The problem is that many don't have willing and able family, friends or third parties. If what you mean is that the individual will not be considered to be gravely disabled for failing to provide for necessary health care if he or she has a responsible third party to help, then say that. O	11/30/2017 4:02 AM

Q5 Please describe your relationship to the mental health service delivery system (please check all that apply):

Answered: 47 Skipped: 0



ANSWER CHOICES	RESPONSES	
Behavioral Health Advocate	23.40%	11
Behavioral Health Services recipient	0.00%	0
Behavioral Health Services provider	44.68%	21
Government official/employee	53.19%	25
Non-profit official/employee	17.02%	8
For-profit official/employee	0.00%	0
Other (please specify)	14.89%	7

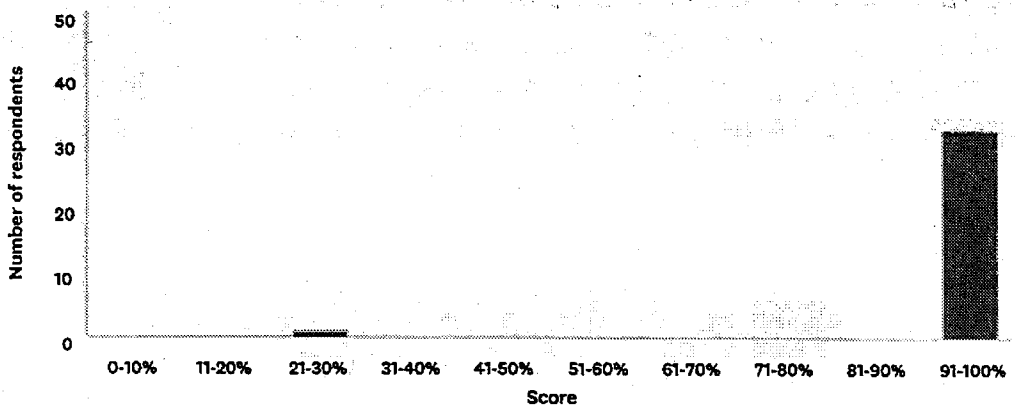
Total Respondents: 47

#	OTHER (PLEASE SPECIFY)	DATE
1	law enforcement	12/5/2017 7:40 PM
2	Loss prevention/risk management consultant.	12/5/2017 7:23 PM
3	Parent of autistic adult with MH & behavior disorder & board member State Council for Developmental disabilities	12/5/2017 5:32 PM
4	Community BH Director	12/4/2017 10:18 PM
5	BH Provider who does policy work in the Department of Corrections	12/4/2017 1:34 PM
6	APS employee also	12/4/2017 11:29 AM
7	loss prevention specialist/risk manager	12/1/2017 2:02 PM

Quiz Summary

AVERAGE SCORE

98% • 3.9/4 PTS



STATISTICS

Lowest Score	Median	Highest Score
25%	100%	100%

Mean: 98%

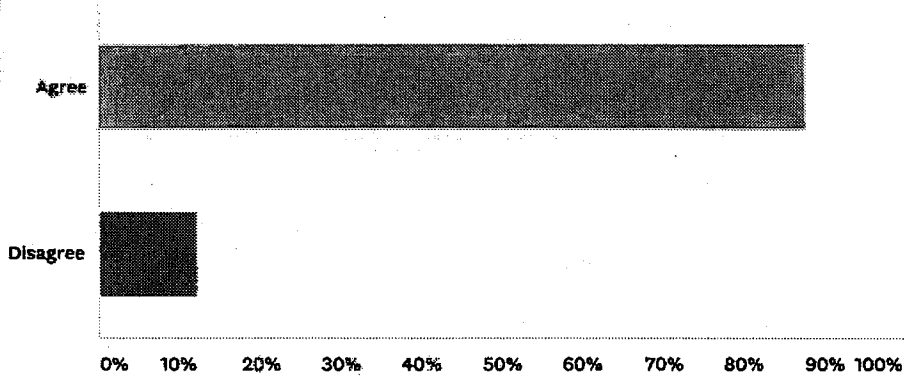
Standard Deviation: 13%

Question Ranking

QUESTIONS (4)	DIFFICULTY	AVERAGE SCORE
Q3 The nature of the individual's physical health need(s) must be apparent, progressing, and at predictable risk of becoming life/limb threatening.	1	100%
Q2 Assessment of physical health needs under the proposed definition must be conducted by a licensed physician over a meaningful course of monitoring and attempting to engage in treatment.	1	100%
Q4 Due to a mental illness, the individual is not capable of surviving safely without the help of immediate medical attention for a serious and active physical health condition.	1	100%
Q1 Current Definition: A condition in which a person, as a result of a mental disorder (or impairment by chronic alcoholism), is unable to provide for his (or her) basic personal needs for food, clothing or shelter. (Welfare & Institutions Code section 5008(h)(l)(A),(2))Proposed Definition: A condition in which a person, as a result of a mental disorder (or impairment by chronic alcoholism), is unable to provide for his (or her) basic personal needs for food, clothing, shelter or medical needs.	1	100%

Q1 Current Definition: A condition in which a person, as a result of a mental disorder (or impairment by chronic alcoholism), is unable to provide for his (or her) basic personal needs for food, clothing or shelter. (Welfare & Institutions Code section 5008(h)(I)(A),(2))Proposed Definition: A condition in which a person, as a result of a mental disorder (or impairment by chronic alcoholism), is unable to provide for his (or her) basic personal needs for food, clothing, shelter or medical needs.

Answered: 33 Skipped: 0



QUIZ STATISTICS

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100%	1.0/1.0 (100%)	0.00	1/4

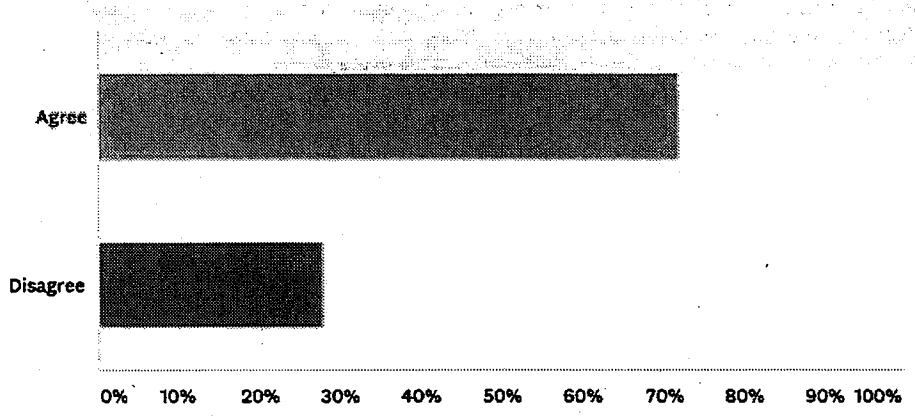
ANSWER CHOICES	SCORE	RESPONSES	
✓ Agree	1/1	87.88%	29
✓ Disagree	1/1	12.12%	4
TOTAL			33

#	COMMENT:	DATE
1	Medical needs provides whole person care / I think they need to get rid the word alcoholism and put substance abuse_addiction or something broader than alcohol.	12/26/2017 7:56 PM
2	Does this specifically include other substance abuse impairment as well?	12/23/2017 12:22 PM
3	The proposed definition meet the needs of those that are currently facing many more conditions that are brought on by today's society. The old definition is so outdated that it does not help those that are in dire need today.	12/22/2017 4:26 PM
4	short & sweet.....	12/21/2017 10:42 PM
5	medical needs is too broad, should be narrowed to physical health needs resulting in puttting the person in danger of serious harm	12/19/2017 8:18 PM
6	We need to add the degenerative impact drug use on the mental stability of some users.	12/19/2017 7:05 PM
7	Would this include medication or medication management?	12/19/2017 6:38 PM
8	What about impairment resulting from drug addiction?	12/19/2017 6:37 PM

9	I would suggest some language around personal safety issues. Many are women whose behaviors put them at risk for violence and sexual assault.	12/19/2017 1:31 PM
10	The ability to comment is made difficult by this format. I have observed a pattern of Court 95.A not considering chronic alcoholism or drug addiction as a reason to grant Conservatorship. First, I recommend that chronic alcoholism and other drug dependent disorders be in this definition. Also, I recommend that there be training for judges, PDs, Psychiatrists and all involved to understand this inclusion.	12/19/2017 10:50 AM
11	I have seen this deterioration of a family member and has frequently not been deemed to meet the current definition. The proposed definition would much more useful in trying to help him with his mental illness, particularly as he is currently homeless because of the illness.	12/19/2017 9:57 AM

Q2 Assessment of physical health needs under the proposed definition must be conducted by a licensed physician over a meaningful course of monitoring and attempting to engage in treatment.

Answered: 32 Skipped: 1



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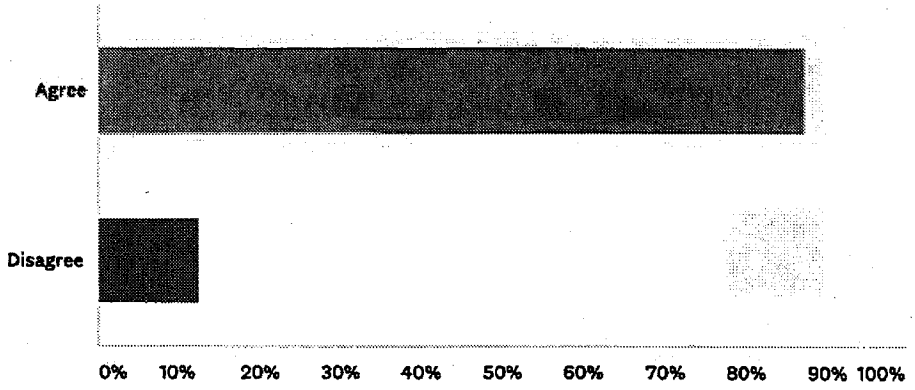
97%	1.0/1.0 (100%)	0.00	1/4

ANSWER CHOICES	SCORE	RESPONSES	
✓ Agree	1/1	71.88%	23
✓ Disagree	1/1	28.13%	9
TOTAL			**32**

#	COMMENT:	DATE
1	Why not include other licensed medical professionals? Seems would need to for this to work.	12/22/2017 9:10 PM
2	Should not be limited to licensed physician, but expanded to include other licensed health care providers (ex. licensed nurse practitioner), who may be more readily accessible to a more transient (ex. homeless) community.	12/22/2017 6:36 PM
3	Physicians are not out in the field so this will block the majority of efforts to get a person on 5150 status. Some of these people are dying on the street.	12/22/2017 5:36 PM
4	There are MANY times when it is obvious to a non medical staff member that there is an urgent medical need that will not be addressed without intervention, and slowing the process down is dangerous.	12/22/2017 1:51 PM
5	good oversight.....	12/21/2017 10:42 PM
6	You must add a license psychiatrist to determine mental stability to address normal human needs.	12/19/2017 7:05 PM
7	"Over a meaningful course of monitoring" lacks clarity of measurable decision making.	12/19/2017 6:38 PM
8	Would this also include Nurse Practitioners?	12/19/2017 1:31 PM
9	Also, the family's historical information must be considered.	12/19/2017 10:50 AM
10	Yes I totally agree with this.	12/19/2017 9:57 AM

Q3 The nature of the individual's physical health need(s) must be apparent, progressing, and at predictable risk of becoming life/limb threatening.

Answered: 32 Skipped: 1



QUIZ STATISTICS

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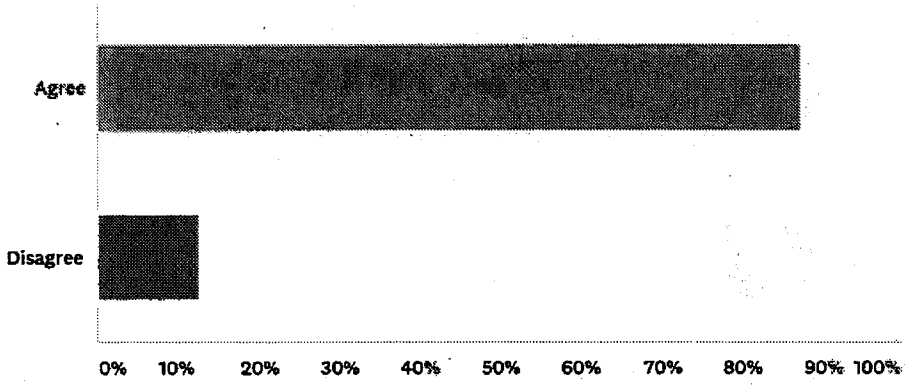
97%	1.0/1.0 (100%)	0.00	1/4

ANSWER CHOICES	SCORE	RESPONSES	
✓ Agree	1/1	87.50%	28
✓ Disagree	1/1	12.50%	4
TOTAL			32

#	COMMENT:	DATE
1	Cancer? Diabetes? Not so apparent but life threatening.	12/22/2017 9:10 PM
2	well said....	12/21/2017 10:42 PM
3	Would suggest use of word "deteriorating" as opposed to "progressing".	12/19/2017 6:38 PM
4	What if it's not progressive disease or disorder? Does it have to include all of the above factors?	12/19/2017 6:37 PM
5	I object to must be apparent. Also, to whom must it be apparent?	12/19/2017 1:31 PM
6	Again, include family's documentation.	12/19/2017 10:50 AM
7	However, it is not always easy to witness the above if an individual is homeless. How can you see this if they do not live somewhere where they can be observed ?	12/19/2017 9:57 AM

Q4 Due to a mental illness, the individual is not capable of surviving safely without the help of immediate medical attention for a serious and active physical health condition.

Answered: 32 Skipped: 1



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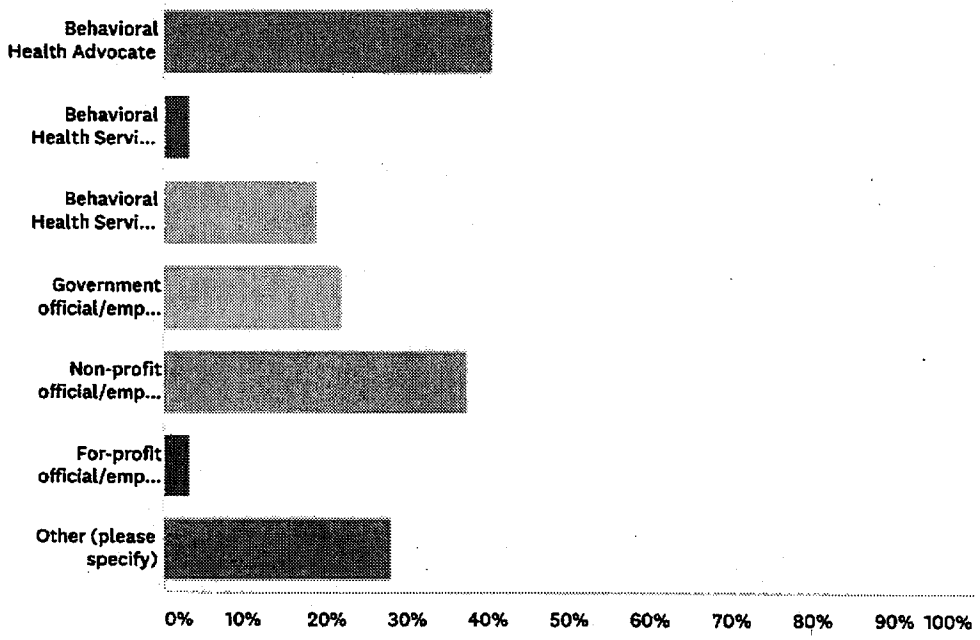
97%	1.0/1.0 (100%)	0.00	1/4

ANSWER CHOICES	SCORE	RESPONSES	
✓ Agree	1/1	87.50%	28
✓ Disagree	1/1	12.50%	4
TOTAL			**32**

#	COMMENT:	DATE
1	State law should be expanded to include medical needs. For example: Someone was so impaired that they were unable to go to dialysis and ended up dying because of untreated medical needs.	12/26/2017 7:56 PM
2	and medical emergency attention ASAP....	12/21/2017 10:42 PM
3	I'm wondering about the word "attention", thinking "intervention" might be more appropriate.	12/19/2017 6:38 PM
4	Due to a mental illness, including chronic alcoholism and drug dependence.	12/19/2017 10:50 AM

Q5 Please describe your relationship to the mental health service delivery system (please check all that apply):

Answered: 32 Skipped: 1



ANSWER CHOICES	RESPONSES	
Behavioral Health Advocate	40.63%	13
Behavioral Health Services recipient	3.13%	1
Behavioral Health Services provider	18.75%	6
Government official/employee	21.88%	7
Non-profit official/employee	37.50%	12
For-profit official/employee	3.13%	1
Other (please specify)	28.13%	9

Total Respondents: 32

#	OTHER (PLEASE SPECIFY)	DATE
1	Volunteer	12/26/2017 10:52 PM
2	Los Angeles County, Health Agency - Mental Health current consumer	12/26/2017 7:56 PM
3	Former client, presently a volunteer with LACDMH, Peer Advocate, etc.	12/22/2017 4:26 PM
4	MH community advocate & organizer	12/21/2017 10:42 PM
5	Community and client advocate	12/19/2017 7:05 PM
6	Volunteer LACDMH	12/19/2017 6:38 PM
7	Retired CEO of a mental health contract agency.	12/19/2017 6:37 PM
8	Chair of the Executive Board - Faith Based Advocacy Council	12/19/2017 9:57 AM

9	Consumer	12/19/2017 9:39 AM

Q6 Any additional comments? And thanks so much for your time and input on this vital topic!

Answered: 14 Skipped: 19

#	RESPONSES	DATE
1	When, How, and Where will these results be publicly available? Thank you for your time and consideration on this topic and being open-minded to include feedback from others who are also interested. National Consumer Motto: "Nothing About Us Without Us"	12/26/2017 10:52 PM
2	Thank you, for the opportunity as an end user of service to participate. Reba Stevens	12/26/2017 7:56 PM
3	Sometimes people are danger to self because they don't have insight into their need for help. The physical need may not be obvious or they may not have one. But the psychiatric need is great and the person is blocked by his illness (say paranoia) from accepting help. As a result they do not eat properly and are exposed to the elements for extended periods of time, greatly deteriorating their health.	12/22/2017 5:36 PM
4	Change with service deliverance in the Black & Brown Community is so much needed to keep up with times.	12/22/2017 4:26 PM
5	Although persons with physical health issues are entitled to health care at times may lead to a permanent or temporary disability. If alcoholism is addictive how does it compare to mental illness, a disorder in some circumstances can not be changed. In some aspects this survey puts mental illness and alcoholism in the same category. A decision to stop drinking can suspend the addiction to alcoholism but some mental disorders are not capable of suspending the effects of mental illness. I am just curious about the connection between addiction and disorder.	12/22/2017 2:55 PM
6	I think this would be a very helpful and relevant change to the code.	12/22/2017 1:51 PM
7	I believe assessing and adding the health risk, will assist in those individuals, who have a lack of insight into their condition	12/22/2017 1:49 PM
8	Gracias, Ricardo Pulido Nami/LAC Ed. Coord. 310-567-0748 rick@namilaccc.org contact me f you need more insight!....rp	12/21/2017 10:42 PM
9	This is an important issue and we need to get it Wright.	12/19/2017 7:05 PM
10	I believe the junction between mental health and physical health must be addressed concurrently in order to achieve the best overall outcomes.	12/19/2017 6:38 PM
11	Sometimes the more specific you are in the definition of what qualifies as a mental health disorder and a need for care the more different areas are identified as missing in the definition.	12/19/2017 6:37 PM
12	Review requirements for court appearance by attending physician form Psychiatric Hospital.	12/19/2017 1:31 PM
13	Co-occurring Disorders must be addressed in all the above. Research, training and treatment are critical.	12/19/2017 10:50 AM
14	It should be easier for family members of someone with a mental illness to get help for their family member. There are many wonderful services offered, but not enough people to provide them, and also not easy to know where to find them. It should be easier for law enforcement to connect with Dept of Mental Health. The jails should not be filled with people who have a mental illness - as this is the only recourse that law enforcement has. Can there not be a better solution found for people who are not a danger to the public but nevertheless can be annoying - other than arresting or giving citations for them to show up in court? Most people don't even know that they have to show up, and then have a bench warrant issued for their arrest. I wonder if there could be a better way of attending these issues - all connected to Section 5008	12/19/2017 9:57 AM

Kathy Jones

From: Brittney Weissman <brittney@namilaccc.org>
Sent: Monday, October 30, 2017 4:52 PM
To: Kerry Morrison
Subject: Re: Recommendations to LAC Board of Supervisors

Ah! Kerry. What a day. Spent the morning with stakeholders at the LPS meeting and the afternoon touring Skid Row with Anthony, Steve Lopez, Dr. Shaner, Susan Partovi and Sup Barger. Yes, please DO send a letter to Sheila Kuehl's office. From what I understand she is reluctant to support the motion tomorrow. Susan, Emily De Fraites and I will speak in support tomorrow. Still have to prepare my comments.

Brittney Weissman
Executive Director
NAMI Los Angeles County Council
3250 Wilshire Boulevard, Suite 1501
Los Angeles, CA 90010
(818) 687-1657
Brittney@namilaccc.org
www.namilacc.org
www.facebook.com/NAMILACC.org

NAMI National Alliance on Mental Illness | Los Angeles County Council

On Oct 30, 2017, at 4:39 PM, Kerry Morrison <Kerry@hollywoodbid.org> wrote:

Brittney, this is great news. I won't be able to be at the BOS manana, but were you able to get a few more people to speak in favor? Do I need to send a letter to Sheila Kuehl, or is she on board?
Kerry

KERRY MORRISON
Executive Director

[Hollywood Property Owners Alliance]
6562 Hollywood Blvd | Los Angeles, CA 90028
323.463-6767 | kerry@hollywoodbid.org | onlyinhollywood.org

From: Brittney Weissman [mailto:brittney@namilaccc.org]
Sent: Friday, October 27, 2017 3:48 PM
To: Stephany Campos <scampos@hhcla.org>
Cc: Jeffrey Arnold <jeffrey.r.arnold@lacity.org>; Sieglinde Von Deffner <svondeffner@dhs.lacounty.gov>; Joel Braslow <jbraslow@ucla.edu>; Miriam Brown

<MBrown@dmh.lacounty.gov>; Cameron Langhans <cameronlanghans@gmail.com>; Caroline Kelly <chairlamhc@gmail.com>; Richard Van Horn <rvanhorn@mhala.org>; Jackelyn Lawson <jacquelyn.lawson@lacity.org>; Anthony Ruffin <ruffin00@gmail.com>; Roderick Shaner <RShaner@dmh.lacounty.gov>; Kerry Morrison <Kerry@hollywoodbid.org>; Amie Quigley <aquigley@fpch.org>; Gregory Parker <31685@lapd.online>; Emily DeFraites <edefrai@gmail.com>; Nicholas Greif <nicholas.greif@lacity.org>; Susan Lee <Susan.Lee@csh.org>; Scot Fears <fears.scott@gmail.com>; Loretta Y. Howitt <Loretta.Y.Howitt@kp.org>; Celina Alvarez <calvarez@housingworksca.org>; Sarah Dusseault <sarah.dusseault@lacity.org>; Susan Partovi <susanpartovi@gmail.com>; Jim Preis <jpreis@mhas-la.org>; Gina Di Domenico <gina.m.didomenico@lacity.org>; Amber Roth <aroth@hhcla.org>; Connie Draxler <CDraxler@dmh.lacounty.gov>; Leslie Smith <lsmith@counsel.lacounty.gov>; Gita O'neill <gita.oneill@lacity.org>; La Tina Jackson <LTJackson@dmh.lacounty.gov>; Ben Conway <bconway@publiccounsel.org>; Mark Casanova <mcasanova@hhcla.org>; Philippe Bourgois <bourgois@ucla.edu>; Sarah Evans <sevans@publiccounsel.org>; Martin Schlageter <martin.schlageter@lacity.org>; Ari Simon <ari.simon@lacity.org>; Sarah Short <saras@lampcommunity.org>; Mark Gale <markgale510@gmail.com>
Subject: Re: Recommendations to LAC Board of Supervisors

Hi all —

Heads up! On next Tuesday, Supervisor Barger is bringing a motion to ask DMH, county counsel and others to present legislative proposals to the Board to expand the definition of grave disability. One of the recommendations in the DMH strategic plan presented at the BOS meeting a couple of weeks ago is to support legislation to expand the definition of "gravely disabled" to include a person's inability to provide medical care for him or herself due to a mental disorder. This was a focus for our work group and next week's motion furthers that work. See the motion here:

http://file.lacounty.gov/SDSInter/bos/supdocs/117815.pdf

Are any of you available to join me in providing supportive comments?

Brittney

Brittney Weissman
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www.facebook.com/NAMILACC.org

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> On Oct 20, 2017, at 4:16 PM, Stephany Campos <scampos@hhcla.org> wrote:
>
> Hello Group,
>
> Sarah at Public Counsel, brought this article to our attention: http://www.scpr.org/news/2017/10/17/76751/la-officials-struggle-with-options-for-homeless-wi/

As you will see, "Supervisors unanimously voted to pursue the suggestions, **except for one** — an expanded definition of 'gravely disabled' to include those with medical issues who don't pursue treatment "due to a mental disorder."

The good news is all of the other recommendations were agreed upon by the Supervisors to look into. For the time being, they decided to table the idea of an expanded definition.

Thank you, Sarah, for the update. We will continue to track the progress of the recommendations.

Have a great weekend.

Stephany Campos | Executive Administrator/Programs Manager
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2330 Beverly Blvd., Los Angeles, CA 90057
(O) 213.381.0539 | (F) 213.739.1617

Check out our new website. www.hhcla.org

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From: Stephany Campos <scampos@hhcla.org>
Date: Thursday, October 19, 2017 at 2:33 PM
To: Jeffrey Arnold <jeffrey.r.arnold@lacity.org>, "Mgale510@aol.com" <mgale510@aol.com>, Sieglinde Von Deffner <svondeffner@dhs.lacounty.gov>, Joel Braslow <jbraslow@ucla.edu>, Miriam Brown <MBrown@dmh.lacounty.gov>, Cameron <cameronlanghans@gmail.com>, "Caroline Kelly (chairlamhc@gmail.com)" <chairlamhc@gmail.com>, "Van Horn, Richard" <rvanhorn@mhala.org>, Jacquelyn Lawson <jacquelyn.lawson@lacity.org>, Anthony Ruffin <ruffin00@gmail.com>, Roderick

Shaner <RShaner@dmh.lacounty.gov>, Kerry Morrison <kerry@hollywoodbid.org>, Amie Quigley <aquigley@fpch.org>, Gregory Parker <31685@lapd.online>, Emily DeFraites <edefrai@gmail.com>, Nicholas Greif <nicholas.greif@lacity.org>, Brittney Weissman <brittney@namilaccc.org>, Susan Lee <Susan.Lee@csh.org>, Scot Fears <fears.scott@gmail.com>, "Loretta Y. Howitt" <Loretta.Y.Howitt@kp.org>, Celina Alvarez <calvarez@housingworksca.org>, Sarah Dusseault <sarah.dusseault@lacity.org>, "Susan Partovi (susanpartovi@gmail.com)" <susanpartovi@gmail.com>, Jim Preis <jpreis@mhas-la.org>, Gina Di Domenico <gina.m.didomenico@lacity.org>, Amber Roth <aroth@hhcla.org>, Connie Draxler <CDraxler@dmh.lacounty.gov>, Leslie Smith <lsmith@counsel.lacounty.gov>, Gita O'neill <gita.oneill@lacity.org>, La Tina Jackson <LTJackson@dmh.lacounty.gov>, Ben Conway <bconway@publiccounsel.org>, Mark Casanova <mcasanova@hhcla.org>, Philippe Bourgois <bourgois@ucla.edu>, Sarah Evans <sevans@publiccounsel.org>, Martin Schlageter <martin.schlageter@lacity.org>, Ari Simon <ari.simon@lacity.org>, Sarah Short <saras@lampcommunity.org>
Subject: Recommendations to LAC Board of Supervisors

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I hope this message finds you all well.

Attached you will find the list of 13 recommendations the Los Angeles Department of Mental Health provided to the Los Angeles County Board of Supervisors. Our working group (subcommittee) was recognized and our suggestions were mentioned. For example, recommendation 5 calls for the definition of gravely disabled to be broadened. Many of the recommendations increase DMH's role on the issue of how we treat those in our community that are gravely disabled.

Thank you again for your participation in our subcommittee. We will continue to keep you posted with related updates.

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Check out our new website. www.hhcla.org

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Kathy Jones

From: Susan Partovi <susanpartovi@gmail.com>
Sent: Friday, October 27, 2017 11:17 PM
To: Brittney Weissman
Cc: Stephany Campos; Jeffrey Arnold; Sieglinde Von Deffner; Joel Braslow; Miriam Brown; Cameron Langhans; Caroline Kelly; Richard Van Horn; Jackelyn Lawson; Anthony Ruffin; Roderick Shaner; Kerri Morrison; Amie Quigley; Gregory Parker; Emily DeFraites; Nicholas Greif; Susan Lee; Scot Fears; Loretta Y. Howitt; Celina Alvarez; Sarah Dusseault; Jim Preis; Gina Di Domenico; Amber Roth; Connie Draxler; Leslie Smith; Gita O'neill; La Tina Jackson; Ben Conway; Mark Casanova; Philippe Bourgois; Sarah Evans; Martin Schlageter; Ari Simon; Sarah Short; Mark Gale
Subject: Re: Recommendations to LAC Board of Supervisors

Hi Brittney. What time is this at? How do we present what are work group did?

On Fri, Oct 27, 2017 at 3:47 PM, Brittney Weissman <brittney@namilaccc.org> wrote:
Hi all —

Heads up! On next Tuesday, Supervisor Barger is bringing a motion to ask DMH, county counsel and others to present legislative proposals to the Board to expand the definition of grave disability. One of the recommendations in the DMH strategic plan presented at the BOS meeting a couple of weeks ago is to support legislation to expand the definition of "gravely disabled" to include a person's inability to provide medical care for him or herself due to a mental disorder. This was a focus for our work group and next week's motion furthers that work. See the motion here:

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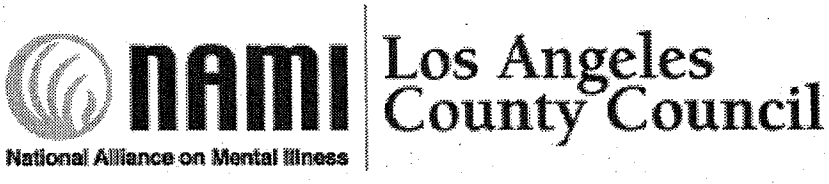

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Subject: Recommendations to LAC Board of Supervisors

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Kathy Jones

From: Kerry Morrison <Kerry@hollywoodbid.org>
Sent: Thursday, February 08, 2018 5:41 PM
To: Brittney Weissman
Cc: Caroline Kelly; Barbara B Wilson
Subject: RE: Some fact checking -- Brentwood Manor

I think it would be helpful if we could find some caseworkers who might have knowledge that there were people living there with mental illness.

Or maybe someone from CCLD would have records that would show the demographic of who lived there. I think that sometimes these board and care homes suggest they serve elderly but they serve a wider audience. I know that is the case with Bel Air, which is on Stanley off of Sunset. On the sign, it says retirement living, but many mentally ill residents, who are not of retirement age live there.

Kerry

KERRY MORRISON
Executive Director

[Hollywood Property Owners Alliance]
6562 Hollywood Blvd | Los Angeles, CA 90028
323.463-6767 | kerry@hollywoodbid.org | onlyinhollywood.org

From: Brittney Weissman [mailto:brittney@namilaccc.org]
Sent: Thursday, February 8, 2018 7:41 AM
To: Kerry Morrison <Kerry@hollywoodbid.org>
Cc: Caroline Kelly <carolinekelly3@gmail.com>; Barbara B Wilson <barbarabwilsonlcsw@gmail.com>
Subject: Re: Some fact checking -- Brentwood Manor

I could call today. Do you have a specific contact at Neighborhood Legal Services? I see on their website they list general numbers/emails. Otherwise, don't know how we'd verify. Barbara, any ideas?

Brittney

Brittney Weissman
Executive Director
NAMI Los Angeles County Council
3250 Wilshire Boulevard, Suite 1501
Los Angeles, CA 90010
(818) 687-1657
Brittney@namilaccc.org
www.namilacc.org
www.facebook.com/NAMILACC.org

On Feb 7, 2018, at 9:27 PM, Kerry Morrison <Kerry@hollywoodbid.org> wrote:

Ladies, I am working on our powerpoint for the HHH committee next week.

In our report, we reference Brentwood Manor, as a B/C that closed. We link to a story about how it was sold to a developer to create a boutique hotel. A very compelling story – but we need to verify a few things.

This article (about how the court had to step in and protect people from evictions) says it was a residence for elderly and disabled. Would the disabled be people with mental illness? Can we confirm? http://www.nlsla.org/blog/judge-orders-west-la-elder-care-facility-to-stop-abuse-evictions/

The address cited in these various articles is 1449 Wellesley Ave but our report says 12311 West Santa Monica Blvd.

So, can we confirm that people with mental illness lived there, and had to be relocated to make way for the sale? And would the address actually be on Wellesley Avenue?

Kerry

Kathy Jones

From: Barbara B Wilson <barbarabwilsonlcsw@gmail.com>
Sent: Tuesday, February 20, 2018 9:31 PM
To: La Tina Jackson
Cc: Brittney Weissman; Caroline; Eva Carrera; Kerry Morrison; stacy dalgleish
Subject: Re: Bed Availability

I was looking for/couldn't locate a license number. Can u show me ? To my knowledge he has all Unlicenced facilities although they market to the lafsa requirements.
They charge $750/month and r part of a general relief pilot program so GR pays $500. Theoretically the resident pays $225 but often they don't pay. [redacted] Residents have to use their food stamps to front the cost of the meal.
New regulations from LAHSA. They can only House 2 per room so the revenue has gone down.

There is no requirement for them to send the vacancies out. They send it to discharge planners, social workers etc to aid in referrals.

Barbara

On Tue, Feb 20, 2018 at 10:42 AM La Tina Jackson <LTJackson@dmh.lacounty.gov> wrote:

> Thanks, Barbara. Below it has a license number. Is this an operator that has both types of facilities? Also who is the update sent to and who manages the be availability on a day: day basis?
>
> La Tina M. Jackson, LCSW District Chief
>
> Service Area 2 Administration
>
> 6800 Owensmouth Avenue #160
>
> Canoga Park, CA 91303
>
> Office: 818-610-6708
>
> Cell: 213-864-6338
>
> **From:** Barbara B Wilson [mailto:barbarabwilsonlcsw@gmail.com]
> **Sent:** Monday, February 19, 2018 11:54 PM
> **To:** Caroline; Brittney Weissman; Lisa Kodmur; Kerry Morrison; stacy dalgleish
> **Cc:** La Tina Jackson; Eva Carrera
> **Subject:** Fwd: Bed Availability

Here is an example of what the Unlicensed Facility sends in to update their bed availability FYI.

Barbara

---------- Forwarded message ----------
From: **A Better Living Permanent Housing and Supportive Services** <abetterliving@outlook.com>
Date: Mon, Feb 19, 2018 at 1:46 PM
Subject: Bed Availability
To: Crystal LaRochelle <crystal.larochelle@gmail.com>

Good Afternoon, below is the bed Availability. Please call the office with any questions (818) 810-5250.

[redacted]

[redacted]

[redacted]

Sincerely,

Crystal Jimenez
Admin Assistant
A Better Living Permanent Housing and Supportive Services

--

Thank you ,

Barbara B Wilson LCSW

Lic#8535

(818)517-9902

--
Thank you ,

Barbara B Wilson LCSW
Lic#8535
(818)517-9902

Kathy Jones

From: Caroline <carolinekelly3@gmail.com>
Sent: Thursday, February 08, 2018 11:30 AM
To: Brittney Weissman
Cc: Kerry Morrison; Barbara B Wilson
Subject: Re: Board and Care

I'm losing emails left and right! I think you already sent it but could someone forward the time location and address of the meeting for HHH so I can forward it to Mary Marx And someone at licensing?

Sent from my iPhone

On Feb 8, 2018, at 7:29 AM, Brittney Weissman <brittney@namilaccc.org> wrote:

> OK, happy to help. Let me know. Thanks!
>
> Brittney
>
> Brittney Weissman
> Executive Director
> NAMI Los Angeles County Council
> 3250 Wilshire Boulevard, Suite 1501
> Los Angeles, CA 90010
> (818) 687-1657
> Brittney@namilaccc.org
> www.namilacc.org
> www.facebook.com/NAMILACC.org
>
> <LACC_colorlowres.jpg>
>
> On Feb 7, 2018, at 7:55 PM, Kerry Morrison <Kerry@hollywoodbid.org> wrote:
>
> Hi Caroline and Barbara,
> See below from CAO's office.
> I sent an email today to Caroline raising the idea that perhaps there should be someone from CCLD and DMH (Mary Marx?) in the room to answer any technical questions that come up.
>
> Working on a powerpoint for the presentation – and we will have to figure out who talks/says what.
> Kerry
>
> **From:** Elyse Azevedo [mailto:elyse.azevedo@lacity.org]
> **Sent:** Wednesday, February 7, 2018 5:11 PM
> **To:** Kerry Morrison <Kerry@hollywoodbid.org>
> **Cc:** Meg Barclay <meg.barclay@lacity.org>
> **Subject:** Re: Board and Care
>
> Hi Kerry, just checking in. Do you have a report and powerpoint to provide for the COC meeting next week?

Additionally, do you have staff lined up from the County to attend and answer questions? If so I can add them to the agenda. Please let me know.

Thank you!

Elyse Matson Azevedo
Office of the City Administrative Officer
213.473.7460
elyse.azevedo@lacity.org

On Wed, Jan 31, 2018 at 10:29 AM, Elyse Azevedo <elyse.azevedo@lacity.org> wrote:

> Thanks Kerry, if you provide me with the powerpoint ahead of time I can make sure we a projector set up for the Committee.
>
> Elyse Matson Azevedo
> Office of the City Administrative Officer
> 213.473.7460
> elyse.azevedo@lacity.org
>
> On Mon, Jan 29, 2018 at 1:59 PM, Meg Barclay <meg.barclay@lacity.org> wrote:
>
> > Sounds great Kerry. We'll add you to the agenda and look forward to seeing the materials. Cc'ing Elyse here. Please send all materials to her. Thanks!
> >
> > On Jan 23, 2018 3:51 PM, "Kerry Morrison" <Kerry@hollywoodbid.org> wrote:
> >
> > > Meg, I've been serving on the ad-hoc subcommittee for the LA County Mental Health Commission to look at the current state of the board and care system as it relates to the mentally ill. We would be ready to report on the agenda for the next meeting of HHH. I'll send you a copy of our report later this week, but I would also put together a simple powerpoint as well.
> > >
> > > Kerry
> > >
> > > ---
> > >
> > > **KERRY MORRISON**
> > > *Executive Director*
> > >
> > > [Hollywood Property Owners Alliance]
> > > 6562 Hollywood Blvd | Los Angeles, CA 90028
> > > 323.463-6767 | kerry@hollywoodbid.org | onlyinhollywood.org

Kathy Jones

From: Barbara B Wilson <barbarabwilsonlcsw@gmail.com>
Sent: Monday, February 19, 2018 11:54 PM
To: Caroline; Brittney Weissman; Lisa Kodmur; Kerry Morrison; stacy dalgleish
Cc: La Tina Jackson; Eva Carrera
Subject: Fwd: Bed Availability
Attachments: WHO WE ARE flyer 2017 revised.docx

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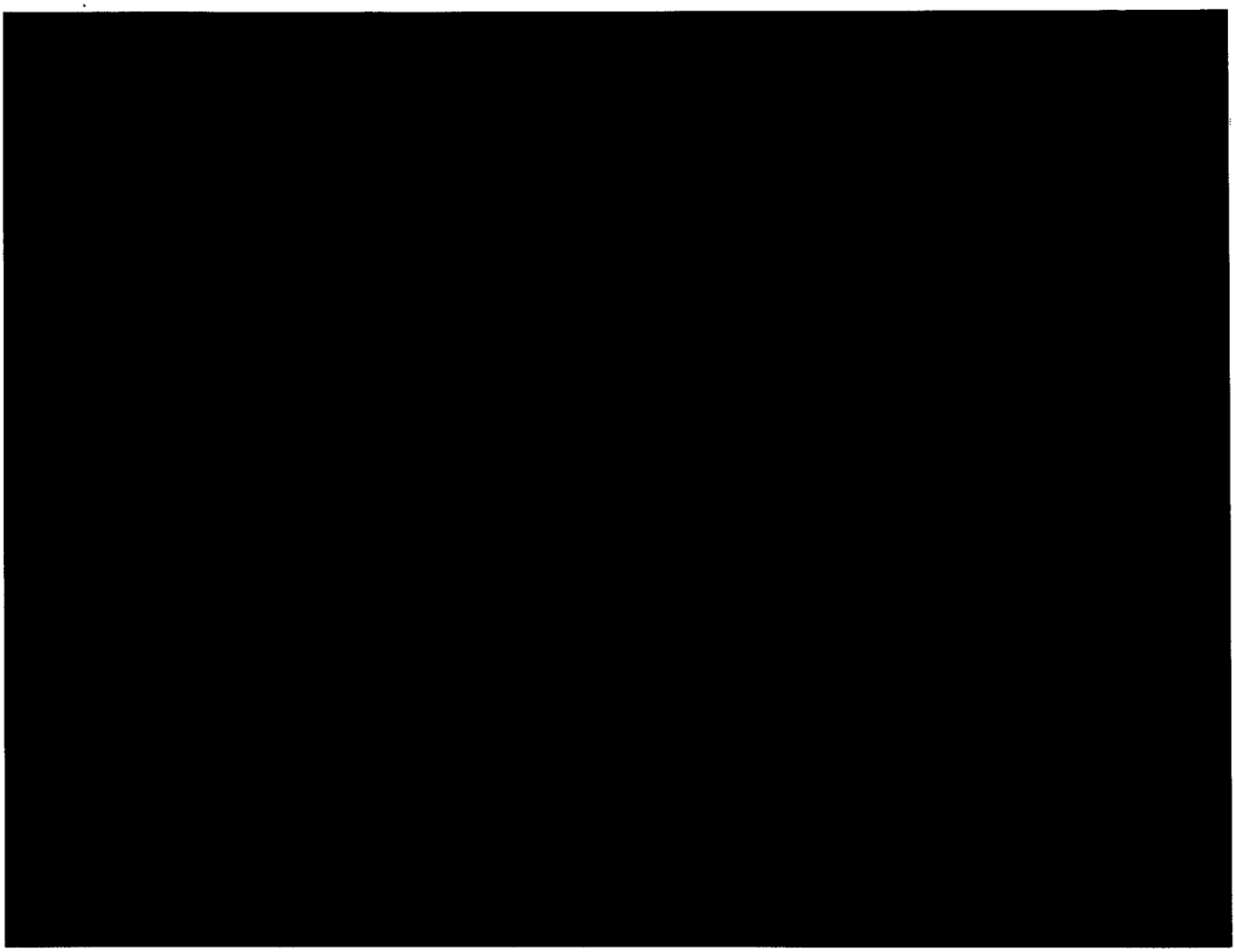
---------- Forwarded message ---------
From: **A Better Living Permanent Housing and Supportive Services** <abetterliving@outlook.com>
Date: Mon, Feb 19, 2018 at 1:46 PM
Subject: Bed Availability
To: Crystal LaRochelle <crystal.larochelle@gmail.com>

Good Afternoon, below is the bed Availability. Please call the office with any questions (818) 810-5250. Thank You.

[redacted]



Sincerely,

Crystal Jimenez
Admin Assistant
A Better Living Permanent Housing and Supportive Services

--

Thank you ,

Barbara B Wilson LCSW
Lic#8535
(818)517-9902

Kathy Jones

From: stacy dalgleish <commissionerstacydalgleish@gmail.com>
Sent: Tuesday, February 20, 2018 2:39 PM
To: Barbara B Wilson
Cc: Caroline; Brittney Weissman; Lisa Kodmur; Kerry Morrison; La Tina Jackson; Eva Carrera
Subject: Re: Bed Availability

Thank you very much Barbara.
Stacy

> On Feb 19, 2018, at 11:54 PM, Barbara B Wilson <barbarabwilsonlcsw@gmail.com> wrote:
>
> Here is an example of what the Unlicensed Facility sends in to update their bed availability FYI.
>
> Barbara

Kathy Jones

From: Barbara B Wilson <barbarabwilsonlcsw@gmail.com>
Sent: Monday, January 29, 2018 7:50 PM
To: Kerry Morrison
Cc: Caroline; Brittney Weissman
Subject: Re: FW: Board and Care

What is the room number for the meeting?

Also, I have a young person who can create merging the documents with the visuals if you would like.

Barbara

On Mon, Jan 29, 2018 at 3:38 PM, Kerry Morrison <Kerry@hollywoodbid.org> wrote:
Committee,
we are on for the 16th at HHH. It is 4 p.m. at City Hall.

Caroline, I'll have to work with you to get the attachments collected and attached to the core report, so everything can be saved as one pdf.

I'll work on a simple ppt to create a framework for our presentation. I suspect we might get 10 – 15 min total.

Kerry

KERRY MORRISON
Executive Director

[Hollywood Property Owners Alliance]
6562 Hollywood Blvd | Los Angeles, CA 90028
323.463-6767 | kerry@hollywoodbid.org<mailto:kerry@hollywoodbid.org> |
onlyinhollywood.org<http://www.onlyinhollywood.org/>

From: Meg Barclay [mailto:meg.barclay@lacity.org]
Sent: Monday, January 29, 2018 1:59 PM
To: Kerry Morrison <Kerry@hollywoodbid.org>
Cc: Elyse Azevedo <elyse.azevedo@lacity.org>
Subject: Re: Board and Care

Sounds great Kerry. We'll add you to the agenda and look forward to seeing the materials. Cc'ing Elyse here. Please send all materials to her. Thanks!

On Jan 23, 2018 3:51 PM, "Kerry Morrison" <Kerry@hollywoodbid.org<mailto:Kerry@hollywoodbid.org>> wrote:
Meg, I've been serving on the ad-hoc subcommittee for the LA County Mental Health Commission to look at the current state of the board and care system as it relates to the mentally ill. We would be ready to report on

the agenda for the next meeting of HHH. I'll send you a copy of our report later this week, but I would also put together a simple powerpoint as well.

Kerry

KERRY MORRISON
Executive Director

[Hollywood Property Owners Alliance]
6562 Hollywood Blvd | Los Angeles, CA
90028<https://maps.google.com/?q=6562+Hollywood+Blvd+%7C+Los+Angeles,+CA+90028&entry=gmail&source=g>
323.463-6767<tel:(323)%20463-6767> | kerry@hollywoodbid.org<mailto:kerry@hollywoodbid.org> |
onlyinhollywood.org<http://www.onlyinhollywood.org/>

--
Thank you ,

Barbara B Wilson LCSW
Lic#8535
(818)517-9902

Kathy Jones

From: Caroline <carolinekelly3@gmail.com>
Sent: Monday, February 05, 2018 3:31 PM
To: Barbara B Wilson
Cc: Brittney Weissman; Kerry Morrison
Subject: Re: Bed Availability

I'm not sure I understand. Have they expanded to 9 shelter facilities or unlicensed now?

Sent from my iPhone

On Feb 5, 2018, at 3:28 PM, Barbara B Wilson <barbarabwilsonlcsw@gmail.com> wrote:

> Notice that "A Better Living" has expanded handily from 1 fully functioning facility and 1 facility trying to get fully functioning (Corbin) to now 9 sites thanks to the Homeless Reimbursement Rate + Lack of Regulations.
>
> Now that they are forced to put only 2 people per room and are unable to provide "Care & Supervision" because that would require that they obtain Licensure from Community Care Licensing, they are experiencing [redacted]
>
> Barbara

---------- Forwarded message ----------
From: **Barbara B Wilson** <barbarabwilsonlcsw@gmail.com>
Date: Mon, Feb 5, 2018 at 3:23 PM
Subject: Re: Bed Availability
To: A Better Living Permanent Housing and Supportive Services <abetterliving@outlook.com>

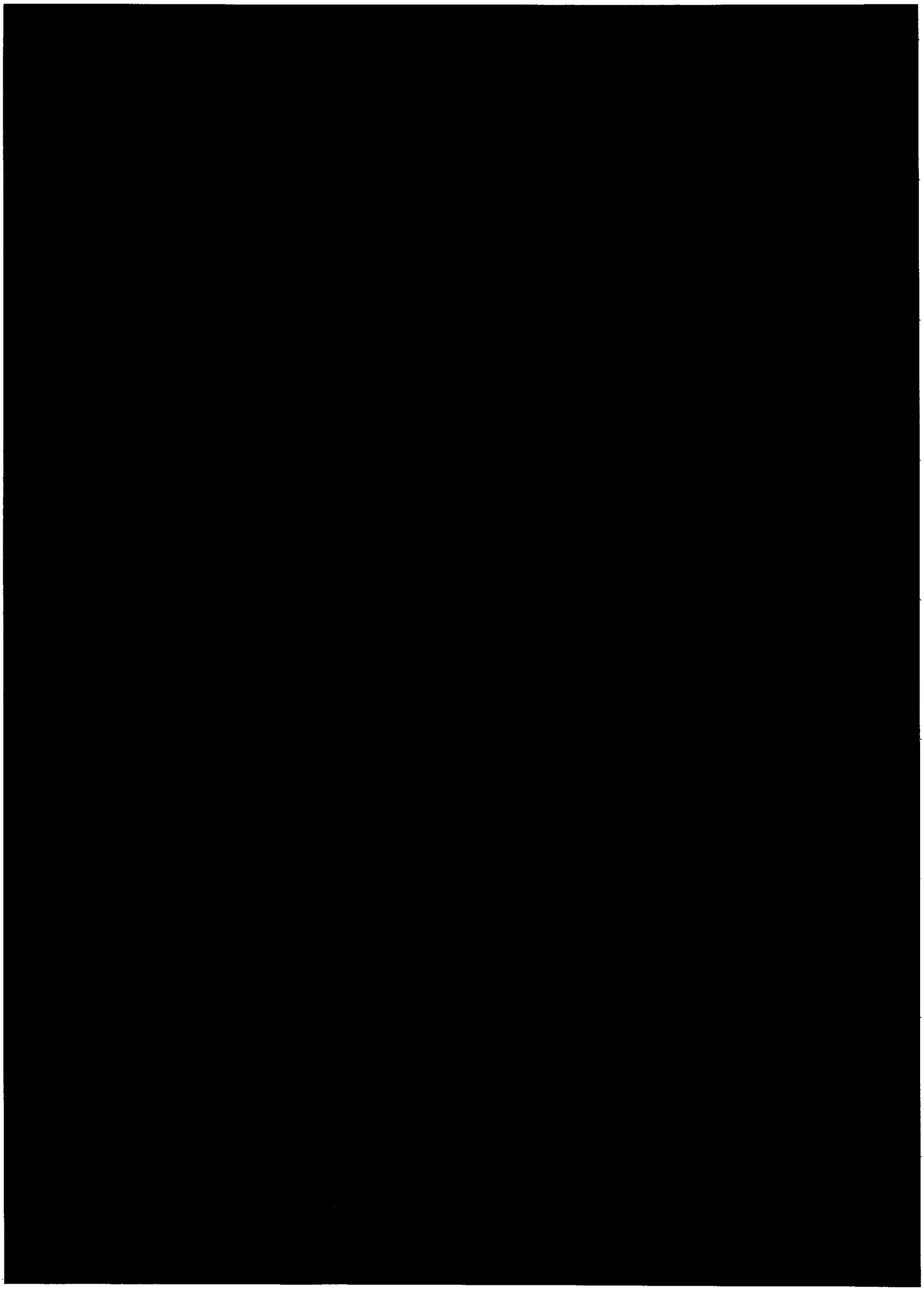
Thank you so very much for providing this update. Also please thank Tim for arranging this site visit for our commissioners et. al.

Barbara B Wilson LCSW
mentalhealthhookup.com

cell: 818-517-9902

On Mon, Feb 5, 2018 at 11:26 AM, A Better Living Permanent Housing and Supportive Services <abetterliving@outlook.com> wrote:
Good Morning, See below bed availability. Please call office with any questions (818) 810-5250. Thank You.

[redacted]



Sincerely,

Crystal Jimenez
Admin Assistant
A Better Living Permanent Housing and Supportive Services

--
Thank you ,

Barbara B Wilson LCSW
Lic#8535
(818)517-9902

--
Thank you ,

Barbara B Wilson LCSW
Lic#8535
(818)517-9902

Kathy Jones

From: Brittney Weissman <brittney@namilaccc.org>
Sent: Thursday, February 08, 2018 7:41 AM
To: Kerry Morrison
Cc: Caroline Kelly; Barbara B Wilson
Subject: Re: Some fact checking -- Brentwood Manor

I could call today. Do you have a specific contact at Neighborhood Legal Services? I see on their website they list general numbers/emails. Otherwise, don't know how we'd verify. Barbara, any ideas?

Brittney

Brittney Weissman
Executive Director
NAMI Los Angeles County Council
3250 Wilshire Boulevard, Suite 1501
Los Angeles, CA 90010
(818) 687-1657
Brittney@namilaccc.org
www.namilacc.org
www.facebook.com/NAMILACC.org

On Feb 7, 2018, at 9:27 PM, Kerry Morrison <Kerry@hollywoodbid.org> wrote:

Ladies, I am working on our powerpoint for the HHH committee next week.

In our report, we reference Brentwood Manor, as a B/C that closed. We link to a story about how it was sold to a developer to create a boutique hotel. A very compelling story – but we need to verify a few things.

This article (about how the court had to step in and protect people from evictions) says it was a residence for elderly and disabled. Would the disabled be people with mental illness? Can we confirm?
http://www.nlsla.org/blog/judge-orders-west-la-elder-care-facility-to-stop-abuse-evictions/

The address cited in these various articles is 1449 Wellesley Ave but our report says 12311 West Santa Monica Blvd.

So, can we confirm that people with mental illness lived there, and had to be relocated to make way for the sale? And would the address actually be on Wellesley Avenue?

Kerry

Kathy Jones

From: La Tina Jackson
Sent: Wednesday, February 21, 2018 8:47 AM
To: Barbara B Wilson
Cc: Brittney Weissman; Caroline; Eva Carrera; Kerry Morrison; stacy dalgleish
Subject: RE: Bed Availability

My apologies Barbra, it was your number listed at the bottom.

La Tina M. Jackson, LCSW District Chief
Service Area 2 Administration
6800 Owensmouth Avenue #160
Canoga Park, CA 91303
Office: 818-610-6708
Cell: 213-864-6338

From: Barbara B Wilson [mailto:barbarabwilsonlcsw@gmail.com]
Sent: Tuesday, February 20, 2018 9:31 PM
To: La Tina Jackson
Cc: Brittney Weissman; Caroline; Eva Carrera; Kerry Morrison; stacy dalgleish
Subject: Re: Bed Availability

I was looking for/couldn't locate a license number. Can u show me ? To my knowledge he has all Unlicenced facilities although they market to the lafsa requirements.
They charge $750/month and r part of a general relief pilot program so GR pays $500. Theoretically the resident pays $225 but often they don't pay. [redacted] Residents have to use their food stamps to front the cost of the meal.
New regulations from LAHSA. They can [redacted]

There is no requirement for them to send the vacancies out. They send it to discharge planners, social workers etc to aid in referrals.

Barbara

On Tue, Feb 20, 2018 at 10:42 AM La Tina Jackson <LTJackson@dmh.lacounty.gov> wrote:

> Thanks, Barbara. Below it has a license number. Is this an operator that has both types of facilities? Also who is the update sent to and who manages the be availability on a day: day basis?
>
> La Tina M. Jackson, LCSW District Chief
>
> Service Area 2 Administration
>
> 6800 Owensmouth Avenue #160
>
> Canoga Park, CA 91303

Office: 818-610-6708

Cell: 213-864-6338

From: Barbara B Wilson [mailto:barbarabwilsonlcsw@gmail.com]
Sent: Monday, February 19, 2018 11:54 PM
To: Caroline; Brittney Weissman; Lisa Kodmur; Kerry Morrison; stacy dalgleish
Cc: La Tina Jackson; Eva Carrera
Subject: Fwd: Bed Availability

Here is an example of what the Unlicensed Facility sends in to update their bed availability FYI.

Barbara

---------- Forwarded message ----------
From: **A Better Living Permanent Housing and Supportive Services** <abetterliving@outlook.com>
Date: Mon, Feb 19, 2018 at 1:46 PM
Subject: Bed Availability
To: Crystal LaRochelle <crystal.larochelle@gmail.com>

Good Afternoon, below is the bed Availability. Please call the office with any questions (818) 810-5250.
Thank You.

[redacted]

[redacted]

Sincerely,

Crystal Jimenez
Admin Assistant
A Better Living Permanent Housing and Supportive Services

--

Thank you ,

Barbara B Wilson LCSW

Lic#8535

(818)517-9902

--
Thank you ,

Barbara B Wilson LCSW
Lic#8535
(818)517-9902

Kathy Jones

From: Caroline <carolinekelly3@gmail.com>
Sent: Thursday, February 08, 2018 5:35 PM
To: Mary Marx
Cc: Caroline Kelly; Kerry@hollywoodbid.org; brittney@namilaccc.org; barbarabwilsonlcsw@gmail.com
Subject: HHH meeting with board and care

Hi Mary,
The information below is for the upcoming HHH meeting. As I mentioned, we think this is a city wide and county wide issue and are trying to seek support and funding from multiple sources to stem the flow of closures. If the committee has technical questions, it would be much better to have an official spokesperson from the department to answer them. If you know who you might send and can provide that in advance, they will add it to the agenda.
Also, can you recommend who at Community licensing would be good to notify as well?

Thanks,
Caroline

HHH Citizens Oversight Committee
Friday February 16
2 p.m. to 4 p.m.
City Hall 200 North Spring Street
Room 1010

From: Elyse Azevedo [mailto:elyse.azevedo@lacity.org]

Sent: Wednesday, February 7, 2018 5:11 PM
To: Kerry Morrison <Kerry@hollywoodbid.org>
Cc: Meg Barclay <meg.barclay@lacity.org>
Subject: Re: Board and Care

Hi Kerry, just checking in. Do you have a report and powerpoint to provide for the COC meeting next week?

Additionally, do you have staff lined up from the County to attend and answer questions? If so I can add them to the agenda. Please let me know.

Thank you!

Elyse Matson Azevedo
Office of the City Administrative Officer
213.473.7460
elyse.azevedo@lacity.org

> On Jan 23, 2018 3:51 PM, "Kerry Morrison" <Kerry@hollywoodbid.org> wrote:

Meg, I've been serving on the ad-hoc subcommittee for the LA County Mental Health Commission to look at the current state of the board and care system as it relates to the mentally ill. We would be ready to report on the agenda for the next meeting of HHH.

Kerry

Kathy Jones

From: Barbara B Wilson <barbarabwilsonlcsw@gmail.com>
Sent: Tuesday, February 13, 2018 12:41 AM
To: Lisa Kodmur
Cc: Caroline; Brittney Weissman; Kerry Morrison; stacy dalgleish
Subject: Re: notes and follow-up from today's phone meeting

Here are some large facilities that are actively considering closing in SPA 2 (valley):

Sunland Manor 100 beds
Alma Lodge 80 beds
Sepulveda Residential 100 beds

That is not to mention the closure in process: Sun Garden/ Tujunga 38 (?) beds Sold to Developers

Smaller Homes under consideration of Closing:

Blake Family Home 6 Beds men
Sharp Family Home 6 Beds men
Amigo Family Home #1, #2 6 Beds men High Functioning
Golden State Lodge 14 Beds, All Female

It should be noted that the potential loss of small facilities really affects the "hands on" care that many residents need immediately following hospitalization or when a resident has never resided out of his own family home. Moreover, small homes tend to have a family atmosphere and often better food, especially if the owner resides on-site. Extra touches such as colored bed-linens, lotioning extra-dry skin, etc are much more likely to be noticed in a small home.

Some anecdotes:

1) Blake Home & Eliza Shanks Home

Both these small 6 bed facilities are currently licensed in the names of two sons, Sam Blake and Austin Shanks. These men were raised in the Family Home culture by their mothers, two African-American sisters who started their homes in neighborhoods that were not especially friendly to either African-Americans or people with mental problems back then. Mrs Shanks has died but Austin keeps the home alive in memory of his mother for now. Sam Blake retired from trucking and returned home to assist his mother, who resides on the premises upstairs, in managing the home. He lives nearby in his own home and has a construction business but cooks dinner nearly every day for the men as well as giving his mother a "vacation" once a month. She is 90 and still very engaged with the residents.

2) Amigo Homes 1&2

These two one-story 6 bed facilities are owned and operated by Liz Bijou. She maintains these homes in memory of her deceased husband and [redacted]. This is [redacted]

3) Alma Lodge was once a pristine facility with gardens. Today there is a tarp on one of the rooftops. Yet there remains good quality care in the facility by staff who really understand how to provide care for people with Serious Mental Illness. Much of the staff has been there for nearly 20 years. [redacted]

Problem: The facility occupies some prime real-estate on Colorado Blvd in Eagle Rock. [redacted]

4) Sunland Manor

This facility has many residents who have resided there for 15 and 20 years. The owner, Ari Rosner, cites that they experience little turnover in staff. [redacted] Meanwhile, the state authorized a very small raise effective January 1.

5) Sharp Family Home

[redacted] They reside on the premises and her husband has really gotten deeply involved in gardening. [redacted] Many of their residents have resided there 10-15 years. [redacted]

6) The one Unlicensed Facility that we visited

Back in approximately 2014 I was introduced to a gentleman who ran an unlicensed facility on a cul-de-sac on [redacted] in Mission Hills. At that time, that facility housed approximately 17 adults: co-ed. He was simultaneously opening a second house on [redacted]

Fast forward to February 2018 and that operation now has 9 facilities ranging from the SFV to Pasadena. They receive [redacted] Because they don't want to be licensed, they do not administer or supervise medications. Neither do they provide much in the way of daily meals. Because they have organized as a non-profit organization, they leverage free donated food which is plentiful for the eye. During the day most of the residents are away to participate in programs or to work, and dinner meal preparation is rotated among the residents.

While this model sounds ideal and would be perfect for residents who are fairly stable, [redacted]. Also they are now required in some of the homes to only place 2 residents per room vs [redacted]

7) An example of Whole Person Care

Back in July 8 I placed a gentleman who had been in the shelter system in Los Angeles. He had suffered both a [redacted]

In the shelter system in Los Angeles he was very slow moving and open to being preyed upon by more able-bodied men. He was in a shelter of approximately 300 men. [redacted]

Upon meeting him, I insisted that he get assessed at the Olive View Psych Urgent Care Center. They found [redacted] return I placed him at the Blake Family Home.

Within a few days [redacted]

There is absolutely no doubt in my mind that absent the care that we were able to provide this gentleman, he would have already died.

8) An example of a TAY person in FSP

I placed a 20-something young man in the Blake Family Home approximately 6 months [redacted]

Today, [redacted]. Before his mother did all of those things for him. In the foreseeable future he will be moving into a brand new apartment. He's decided that [redacted] He took the step of calling in all of us on his support team (both parents, his therapist, his case manager, and me) to announce his plans. This was a big step in him becoming empowered.

These are but a few examples of the daily experiences of serving adults with [redacted] who need Board & Care.

Barbara

On Mon, Feb 12, 2018 at 6:55 PM, Caroline Kelly <carolinekelly3@gmail.com> wrote:
Thank you Lisa for taking such comprehensive notes! Attached is the latest version of the report. As a reminder, we will try and meet for lunch at 12:30 at 120 South Los Angeles St.
Kerry, I went through the draft and made a few more minor revisions--mostly I bolded the headers and bolded key words in the call to action. I also changed the words to a numbered list.

Just as a reminder, the meeting itself is at
HHH Citizens Oversight Committee
Friday February 16
2 p.m. to 4 p.m.
City Hall 200 North Spring Street
Room 1010

On Mon, Feb 12, 2018 at 5:15 PM, Lisa Kodmur <lisakodmur@gmail.com> wrote:
Hi everyone, thank you for an excellent discussion.
I took some notes which include action items in yellow.

Highlights from B&C tour:

- It was good, it was comprehensive
- concerning how pressed owners are financially
- unlikelihood they will be able to continue, and limitations on services
- misalignment of incentives - $50/night for homeless shelter or SRO vs $33/night for ARF
- obligations based on hourly rate are much more significant than I realized. Is there a different equation for calculating how room and board fit in? Dept of Labor has rules about how many hours staff are allowed to work. Dept. of Labor is starting to go to B&Cs and fine them for things like working too many hours without a break, not having staff eat in a separate area.

Prep for HHH metting:

- report should contain all sorts of nuance - it's not just the business model means there's not enough money, but also that Dept. of Labor works against the model
- narrow scope, make sure that Friday presentation addresses not letting these facilities be sold to private developers. Low-interest loans, co-ownership. If big facility gets sold, can't find another place in that area to house 75-100 people.
- HHH is about permanent supportive housing for people who have been on the street for a year or more and have mental illness or addiction. If these facilities close, the residents become homeless and add to the problem.
- Issue for B&C operators: Mary Marx talked about a patch for those who contract with DMH. Operators responded: I've worked so hard to have stable residents, you're going to pay us extra money to bring in someone very unstable? Also cost of insurance to contract with DMH is prohibitive for small facilities.
- Remind the HHH committee: these facilities ARE permanent supportive housing. If you don't support them, they will shut down.
- Equalize the payment for SRO or shelter vs for B&C, or you will incentivize facilities to change to SRO

- BW will bring names of large facilities slated to close and how many beds may be lost in the SFV in the next six months to a year
- LAHSA needs to hear about the misaligned incentives for SRO and B&C
- DMH needs to focus on mentally ill people and necessity of housing as service
- Unlicensed facilities are getting $50/day through their contracts with homeless agencies - they are getting MORE money than B&Cs for FEWER services
- Also, the unlicensed model is not working - they are taking people who are highly unstable and have high medical and mental health needs. B&Cs can better serve these individuals.
- LK will write up a call to action regarding the Assisted Living Waiver and what we need to happen in L.A. County
- How does Whole Person Care fit in? LK will follow up
- Focus on the non-medical services that B&Cs provide, not the housing
- BW: identify some people at Community Care Licensing that we can talk to about facilities changing their billing model
- Can B&Cs charge the med management component separately? Can they do a tiered billing system similiar to the assisted living waiver? Will licensing allow the model to change to meet the changing needs?

Link to a list of facilities statewide that accept the Assisted Living Waiver:
http://www.dhcs.ca.gov/services/ltc/Documents/ListofRCFEfacilities.pdf

Also, the article below was making the rounds among disability rights advocates last week - it's highly critical of the current oversight of assisted living facilities that accept Medicaid dollars. We should be prepared to respond to this report should someone ask about it.

FROM JUSTICE IN AGING:

The Government Accountability Office (GAO) **released a report** this week revealing that lax federal oversight over Medicaid-funded assisted living services threatens the health and safety of more than 330,000 people nationwide who rely on these services.

The GAO's findings are consistent with what Justice in Aging attorneys have seen **in our work** across the country. The federal government largely defers to state assisted living laws when conducting oversight of Medicaid-funded assisted living services. Most of these state laws are inadequate and out-of-step with the higher medical needs of today's assisted living residents, and this puts residents' lives and safety at risk.

The GAO report shows that "critical incidents" such as unexplained deaths, assault, abuse, neglect, financial exploitation, and other serious situations are not tracked and reported adequately or consistently. More than half of the 48 states that provide Medicaid coverage for assisted living could not report the number of critical incidents occurring in assisted living facilities.

Many states do not require any nurse staffing in assisted living facilities. The care is provided primarily by direct care workers whose **caregiving education** may consist solely of an initial training of 15 to 30 hours, and continuing education of 10 or so hours annually, leaving thousands of residents at risk.

Federal legislation is needed to ensure that low-income people who rely on Medicaid receive the care and assistance that they need. We support the GAO recommendations of increased reporting requirements as a first step in the right direction. Adequate reporting, however, is necessary but not sufficient — the federal government also must ensure that assisted living quality of care standards are improved to better protect residents' health, safety and quality of life.

We will keep our network updated and share opportunities to get involved as we work to ensure that low-income older Americans receive the services they need in assisted living, free from abuse and neglect, so they can live with dignity.

Read our full statement on the report.

--

Lisa Kodmur, MPH
310-770-0585
lisakodmur@gmail.com

--
Thank you ,

Barbara B Wilson LCSW
Lic#8535
(818)517-9902

Kathy Jones

From: stacy dalgleish <commissionerstacydalgleish@gmail.com>
Sent: Friday, February 23, 2018 12:21 PM
To: La Tina Jackson
Cc: Barbara B Wilson; Brittney Weissman; Caroline; Eva Carrera; Kerry Morrison
Subject: Re: Bed Availability

As I recall, they said the have a Business License only.
And after expenses, the resident might have $25 a month is spending money. Does this sound accurate to you Barbara?
Stacy

On Feb 21, 2018, at 8:47 AM, La Tina Jackson <LTJackson@dmh.lacounty.gov> wrote:

My apologies Barbra, it was your number listed at the bottom.

La Tina M. Jackson, LCSW District Chief
Service Area 2 Administration
6800 Owensmouth Avenue #160
Canoga Park, CA 91303
Office: 818-610-6708
Cell: 213-864-6338

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I was looking for/couldn't locate a license number. Can u show me ? To my knowledge he has all Unlicenced facilities although they market to the lafsa requirements.
They charge $750/month and r part of a general relief pilot program so GR pays $500. [redacted]
New regulations from LAHSA. They can only House 2 per room so the revenue has gone down.

There is no requirement for them to send the vacancies out. They send it to discharge planners, social workers etc to aid in referrals.

Barbara

On Tue, Feb 20, 2018 at 10:42 AM La Tina Jackson <LTJackson@dmh.lacounty.gov> wrote:

Thanks, Barbara. Below it has a license number. Is this an operator that has both types of facilities? Also who is the update sent to and who manages the be availability on a day: day basis?

La Tina M. Jackson, LCSW District Chief
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6800 Owensmouth Avenue #160
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Subject: Fwd: Bed Availability

Here is an example of what the Unlicensed Facility sends in to update their bed availability FYI.

Barbara

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Thank You.

[redacted]

[redacted]

Sincerely,

Crystal Jimenez
Admin Assistant
A Better Living Permanent Housing and Supportive Services

--
Thank you ,

Barbara B Wilson LCSW
Lic#8535
(818)517-9902

--
Thank you ,

Barbara B Wilson LCSW
Lic#8535
(818)517-9902

Kathy Jones

From: Barbara B Wilson <barbarabwilsonlcsw@gmail.com>
Sent: Saturday, February 24, 2018 4:10 AM
To: Kerry Morrison; Caroline; Brittney Weissman
Subject: Fwd: Friday Citizen's Bond Oversight

---------- Forwarded message ----------
From: **Barbara B Wilson** <barbarabwilsonlcsw@gmail.com>
Date: Sat, Feb 24, 2018 at 4:09 AM
Subject: Re: Friday Citizen's Bond Oversight
To: stacy dalgleish <commissionerstacydalgleish@gmail.com>

I don't know how/whether or not we can track the outcomes of the facilities that closed initially like the Manor. I do know that Kerry Morrison has been trying to obtain what information she could about what the process was, how it was handled and by whom, etc.

It's my belief that this most recent closure, Sun Garden in Tujunga, involved Community Care Licensing and DMH which assisted in re-locating the residents. Not to toot my own horn, but it was only due to my already established ties within the Board & Care community that i got word on New Year's Day that the facility was closing and was able to speak directly with the owner who was really confused about what the process was going to be. She had been promised by the folks negotiating her transaction that All of her staff and All of her residents would be allowed to remain in the facility. So when we talked, she was very distraught because she was just learning that her residents would Not be allowed to stay and that the building was going to be emptied out. I alerted the District Chief, LaTina Jackson who then took whatever action she took. Of course I also alerted the members of the committee (Caroline and Kerry) So it's my impression that no mental health residents became homeless as the result of that closure. However, we also now have No Vacancies in any of the better Board & Care facilities in the entire San Fernando Valley.

Annnyhow, i'll forward your inquiry to Kerry Morrison.

Barbara

On Fri, Feb 23, 2018 at 12:22 PM, stacy dalgleish <commissionerstacydalgleish@gmail.com> wrote:
Hi Barbara,
How can we track what has happened to the residents in the closed facilities? I think this is an important data point to have in our argument for emergency funding for immediate housing.
Stacy

On Feb 20, 2018, at 9:35 PM, Barbara B Wilson <barbarabwilsonlcsw@gmail.com> wrote:

I don't recall all of the facilities in her presentation but yes, the Major and Ferndale have closed. Villa Stanley remains open. Was the other one villa poinsettia? I don't know it's status. Those are all facilities on the Westside

Barbara

On Tue, Feb 20, 2018 at 1:48 PM stacy dalgleish <commissionerstacydalgleish@gmail.com> wrote:
Hi Barbara,
After the Friday meeting Ari mentioned that 4 of the B&Cs referenced in the report had already closed. Could you tell us which they were?
Thanks so much.
Stacy

On Feb 13, 2018, at 12:40 AM, Barbara B Wilson <barbarabwilsonlcsw@gmail.com> wrote:

Here are some large facilities that are actively considering closing in SPA 2 (valley):

Sunland Manor 100 beds
Alma Lodge 80 beds
Sepulveda Residential 100 beds

That is not to mention the closure in process: Sun Garden/ Tujunga 38 (?) beds Sold to Developers

Smaller Homes under consideration of Closing:

Blake Family Home 6 Beds men
Sharp Family Home 6 Beds men
Amigo Family Home #1, #2 6 Beds men High Functioning
Golden State Lodge 14 Beds, All Female

It should be noted that the potential loss of small facilities really affects the "hands on" care that many residents need immediately following hospitalization or when a resident has never resided out of his own family home. Moreover, small homes tend to have a family atmosphere and often better food, especially if the owner resides on-site. Extra touches such as colored bed-linens, lotioning extra-dry skin, etc are much more likely to be noticed in a small home.

Some anecdotes:

1) Blake Home & Eliza Shanks Home
Both these small 6 bed facilities are currently licensed in the names of two sons, Sam Blake and Austin Shanks. These men were raised in the Family Home culture by their mothers, two African-American sisters who started their homes in neighborhoods that were not especially friendly to either African-Americans or people with mental problems back then. Mrs Shanks has died but Austin keeps the home alive in memory of his mother for now. Sam Blake retired from trucking and returned home to assist his mother, who resides on the premises upstairs, in managing the home. He lives nearby in his own home and has a construction business but cooks dinner nearly every day for the men as well as giving his mother a "vacation" once a month. She is 90 and still very engaged with the residents.

2) Amigo Homes 1&2.
These two one-story 6 bed facilities are owned and operated by Liz Bijou. She maintains these homes in memory of her deceased husband and [redacted]

3) Alma Lodge was once a pristine facility with gardens. Today there is a tarp on one of the rooftops. Yet there remains good quality care in the facility by staff who really understand how to provide care for people with Serious Mental Illness. Much of the staff has been there for nearly 20 years. [redacted]

Problem: The facility occupies some prime real-estate on Colorado Blvd in Eagle Rock. [redacted].

4) Sunland Manor

This facility has many residents who have resided there for 15 and 20 years. The owner, Ari Rosner, cites that they experience little turnover in staff. [redacted] Meanwhile, the state authorized a very small raise effective January 1.

5) Sharp Family Home

[redacted] They reside on the premises and her husband has really gotten deeply involved in gardening. [redacted] Many of their residents have resided there 10-15 years. [redacted]

6) The one Unlicensed Facility that we visited

Back in approximately 2014 I was introduced to a gentleman who ran an unlicensed facility on a cul-de-sac on [redacted] in Mission Hills. At that time, that facility housed approximately 17 adults: co-ed. He was simultaneously opening a second house on [redacted]

Fast forward to February 2018 and that operation now has 9 facilities ranging from the SFV to Pasadena. They receive [redacted] Because they don't want to be licensed, they do not administer or supervise medications. Neither do they provide much in the way of daily meals. Because they have organized as a non-profit organization, they leverage free donated food which is plentiful for the eye. During the day most of the residents are away to participate in programs or to work, and dinner meal preparation is rotated among the residents.

While this model sounds ideal and would be perfect for residents who are fairly stable, [redacted] Also they are now required in some of the homes to only place 2 residents per room [redacted].

7) An example of Whole Person Care

Back in July 8 I placed a gentleman who had been in the shelter system in Los Angeles. He had suffered both a [redacted]

In the shelter system in Los Angeles he was very slow moving and open to being preyed upon by more able-bodied men. He was in a shelter of approximately 300 men. [redacted].

Upon meeting him, I insisted that he get assessed at the Olive View Psych Urgent Care Center. They found him [redacted] Upon return I placed him at the Blake Family Home.

Within a few days, [redacted]

[redacted]

There is absolutely no doubt in my mind that absent the care that we were able to provide this gentleman, he would have already died.

8) An example of a TAY person in FSP

I placed a 20-something young man in the Blake Family Home approximately 6 months [redacted]

Today, [redacted] Before his mother did all of those things for him. In the foreseeable future he will be moving into a brand new apartment. He's decided that [redacted] He took the step of calling in all of us on his support team (both parents, his therapist, his case manager, and me) to announce his plans. This was a big step in him becoming empowered.

These are but a few examples of the daily experiences of serving adults with [redacted] who need Board & Care.

Barbara

On Mon, Feb 12, 2018 at 6:55 PM, Caroline Kelly <carolinekelly3@gmail.com> wrote:
Thank you Lisa for taking such comprehensive notes! Attached is the latest version of the report. As a reminder, we will try and meet for lunch at 12:30 at 120 South Los Angeles St.
Kerry, I went through the draft and made a few more minor revisions--mostly I bolded the headers and bolded key words in the call to action. I also changed the words to a numbered list.

Just as a reminder, the meeting itself is at
HHH Citizens Oversight Committee
Friday February 16
2 p.m. to 4 p.m.
City Hall 200 North Spring Street
Room 1010

On Mon, Feb 12, 2018 at 5:15 PM, Lisa Kodmur <lisakodmur@gmail.com> wrote:
Hi everyone, thank you for an excellent discussion.
I took some notes which include action items in yellow.

Highlights from B&C tour:

- It was good, it was comprehensive
- concerning how pressed owners are financially

- unlikelihood they will be able to continue, and limitations on services
- misalignment of incentives - $50/night for homeless shelter or SRO vs $33/night for ARF
- obligations based on hourly rate are much more significant than I realized. Is there a different equation for calculating how room and board fit in? Dept of Labor has rules about how many hours staff are allowed to work. Dept. of Labor is starting to go to B&Cs and fine them for things like working too many hours without a break, not having staff eat in a separate area.

Prep for HHH metting:

- report should contain all sorts of nuance - it's not just the business model means there's not enough money, but also that Dept. of Labor works against the model
- narrow scope, make sure that Friday presentation addresses not letting these facilities be sold to private developers. Low-interest loans, co-ownership. If big facility gets sold, can't find another place in that area to house 75-100 people.
- HHH is about permanent supportive housing for people who have been on the street for a year or more and have mental illness or addiction. If these facilities close, the residents become homeless and add to the problem.
- Issue for B&C operators: Mary Marx talked about a patch for those who contract with DMH. Operators responded: I've worked so hard to have stable residents, you're going to pay us extra money to bring in someone very unstable? Also cost of insurance to contract with DMH is prohibitive for small facilities.
- Remind the HHH committee: these facilities ARE permanent supportive housing. If you don't support them, they will shut down.
- Equalize the payment for SRO or shelter vs for B&C, or you will incentivize facilities to change to SRO
- BW will bring names of large facilities slated to close and how many beds may be lost in the SFV in the next six months to a year
- LAHSA needs to hear about the misaligned incentives for SRO and B&C
- DMH needs to focus on mentally ill people and necessity of housing as service
- Unlicensed facilities are getting $50/day through their contracts with homeless agencies - they are getting MORE money than B&Cs for FEWER services
- Also, the unlicensed model is not working - they are taking people who are highly unstable and have high medical and mental health needs. B&Cs can better serve these individuals.
- LK will write up a call to action regarding the Assisted Living Waiver and what we need to happen in L.A. County
- How does Whole Person Care fit in? LK will follow up
- Focus on the non-medical services that B&Cs provide, not the housing
- BW: identify some people at Community Care Licensing that we can talk to about facilities changing their billing model
- Can B&Cs charge the med management component separately? Can they do a tiered billing system similiar to the assisted living waiver? Will licensing allow the model to change to meet the changing needs?

Link to a list of facilities statewide that accept the Assisted Living Waiver:
http://www.dhcs.ca.gov/services/ltc/Documents/ListofRCFEfacilities.pdf

Also, the article below was making the rounds among disability rights advocates last week - it's highly critical of the current oversight of assisted living facilities that accept Medicaid dollars. We should be prepared to respond to this report should someone ask about it.

FROM JUSTICE IN AGING:

The Government Accountability Office (GAO) **released a report** this week revealing that lax federal oversight over Medicaid-funded assisted living services threatens the health and safety of more than 330,000 people nationwide who rely on these services.

The GAO's findings are consistent with what Justice in Aging attorneys have seen **in our work** across the country. The federal government largely defers to state assisted living laws when conducting oversight of Medicaid-funded assisted living services. Most of these state laws are inadequate and out-of-step with the higher medical needs of today's assisted living residents, and this puts residents' lives and safety at risk.

The GAO report shows that "critical incidents" such as unexplained deaths, assault, abuse, neglect, financial exploitation, and other serious situations are not tracked and reported adequately or consistently. More than half of the 48 states that provide Medicaid coverage for assisted living could not report the number of critical incidents occurring in assisted living facilities.

Many states do not require any nurse staffing in assisted living facilities. The care is provided primarily by direct care workers whose **caregiving education** may consist solely of an initial training of 15 to 30 hours, and continuing education of 10 or so hours annually, leaving thousands of residents at risk.

Federal legislation is needed to ensure that low-income people who rely on Medicaid receive the care and assistance that they need. We support the GAO recommendations of increased reporting requirements as a first step in the right direction. Adequate reporting, however, is necessary but not sufficient — the federal government also must ensure that assisted living quality of care standards are improved to better protect residents' health, safety and quality of life.

We will keep our network updated and share opportunities to get involved as we work to ensure that low-income older Americans receive the services they need in assisted living, free from abuse and neglect, so they can live with dignity.

Read our full statement on the report.

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Lisa Kodmur, MPH
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lisakodmur@gmail.com

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Thank you ,

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Thank you ,

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Kathy Jones

From: Kerry Morrison <Kerry@hollywoodbid.org>
Sent: Thursday, February 15, 2018 7:18 PM
To: Caroline Kelly; Brittney Weissman (brittney@namilaccc.org); Barbara B Wilson (barbarabwilsonlcsw@gmail.com)
Subject: FW: Prop HHH Citizens Oversight Committee Meeting 2/16/18: Agenda and Materials
Attachments: Item 6 - Board and Care Facilities.pdf; Item 7 - United Way Everyone In Presentation.pdf; Agenda Packet.pdf

Ladies, see agenda attached. Feel free to share with anyone who might want to attend the meeting. I'll see you at lunch at 12:15 at the Doubletree.

Kerry

KERRY MORRISON
Executive Director

[Hollywood Property Owners Alliance]
6562 Hollywood Blvd | Los Angeles, CA 90028
323.463-6767 | kerry@hollywoodbid.org | onlyinhollywood.org

From: Elyse Azevedo [mailto:elyse.azevedo@lacity.org]
Sent: Thursday, February 15, 2018 2:25 PM
To: Amelia Williamson <amelia@awaconsults.com>; Blair Besten <blair@historiccore.bid>; Kerry Morrison <Kerry@hollywoodbid.org>; Miguel Santana <miguelsantana2015@gmail.com>; Nicholas Halaris <nhalaris@gmail.com>; Tiffany Boyd <tiffanyboydyouthadvocate@gmail.com>; Tunua Thrash-Ntuk <tthrashntuk@lisc.org>
Cc: Alice Tse <atse@lisc.org>; Elyse Azevedo <Elyse.Azevedo@lacity.org>; Kathy Yeram <yeram@fairplex.com>; Lynel Washington <lynel@awaconsults.com>; Meg Barclay <meg.barclay@lacity.org>; Yolanda Chavez <yolanda.chavez@lacity.org>
Subject: Prop HHH Citizens Oversight Committee Meeting 2/16/18: Agenda and Materials

Good Morning all,

Attached please find the agenda for this Friday's Prop HHH COC meeting, the minutes from last month's meeting, and agenda materials. Please remember that the meeting will be held at **2 p.m.** on **Friday, February 16th** in room 1010 in City Hall. For parking arrangements, please contact me via email with your vehicle's make, year, and license plate number.

Do not hesitate to reach out to me with any questions or concerns. Thank you!

Elyse Matson Azevedo
Office of the City Administrative Officer
213.473.7460
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A Call to Action: The Precarious State of the Board and Care System Serving Residents Living with Mental Illness in Los Angeles County

Prepared by the

Los Angeles County Mental Health Commission

Ad-hoc Committee on LA County's Board and Care System

Members

Caroline Kelly, Immediate Past Chair LA County Mental Health Commission

Barbara B. Wilson, LCSW

Kerry Morrison, Stanton Fellow 2016-17

Brittney Weissman, NAMI LA County Chapter

January 22, 2018

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STATEMENT OF THE PROBLEM

Board and care homes (technically referred to as Adult Residential Facilities) represent a precious and affordable housing resource for individuals suffering from mental illness. These facilities range in size from 6 beds (in a single-family home) to 100+ beds. They are privately operated by homeowners or for-profit corporations. Adult Residential Facilities are 24-hour, non-medical community facilities regulated by the state Community Care Licensing Division. Residents present a continuum of need, ranging from those able to hold down a job on one end of the spectrum, to those who have been released from locked psychiatric facilities on the other end of the spectrum. Yet despite this continuum of need, the daily "rent" paid to a board a care operator in LA County is $35.[1] Operators of board and care homes are increasingly questioning the sustainability of this business model in the face of increasing costs on all fronts (increases in minimum wage, insurance costs, utility increases and accumulated deferred maintenance).

In a preliminary canvasing of board and care operators, the Department of Mental Health believes that in Service Area 2 alone, there may be a closure and loss of as many as 400 beds over the next 18 months. Extrapolated across the county, this results in a significant loss that outpaces the additional housing currently being planned.

Further, given the service needs of this population, the meagre reimbursement does not provide for any type of therapeutic enrichment, community-building or case management.

The board and care system for mentally ill residents is a non-sustainable business model and does not contribute to a meaningful treatment environment which will contribute to a quality of life and/or prevent residents falling back into homelessness. Absent a corrective action, this housing resource will continue to erode.[2]

I. SOLUTION SNAPSHOT

There needs to be an infusion of resources – this year -- into the board and care system to ensure its survival. Supplemental funding, above and beyond what the residents can pay through their government benefits,[3] would provide incentives to operators to continue housing people living with mental illness. The infusion needs to be substantial enough to forestall the loss of precious beds through: (1) the closure of these facilities, (2) the sale of these properties for residential or commercial

[1] For this reimbursement, the board and care must provide three meals a day plus two snacks, a room and bedding, laundry, a well-maintained and safe facility, money management and access to health or psychiatric care professionals.

[2] The long-awaited study from the California Mental Health Planning Council (CMHPC), October 2017, started its report by saying: "This issue paper is the beginning of an effort to highlight a significant public health issue: **the lack of adult residential facilities as housing options for individuals with serious mental illness in California."**

[3] According to the CHMPC October 2017 report, "monthly rates charged by ARF's are driven by the amount of the Social Security Income/State Supplemental Payment (SSI/SSP) amount paid to Californian's with disabilities and who are unable to work. The SSI/SSP payment, as sole source f payment for the individual residing in an ARF, is not sufficient to provide adequate income for the operation of a licensed ARF especially when some about of the SSI/SSP payment is set aside for personal needs of the individuals. Therefore subsidies, often called "patches" are needed." Page 6.

development, or (3) the conversion of these facilities to those serving other populations which offer a higher daily rental rate (e.g., $85 – $150 for homes for individuals with intellectual disabilities).[4] (See Appendix D for additional information.)

Four options are worth exploring to provide these supplemental resources:

a. Reestablishment of the supplemental funding that was made available to LA County board and care facilities up until approximately nine or ten years ago when the head of county DMH Dr. Marvin Southard eliminated this program—and not just to a few places that will take more special cases;
b. Allocation of a portion of the "No Place Like Home" $2B funding that will become available, representing a re-direction of funds already available through the Prop 63 Millionaire's Tax. These funds could be deployed to counteract the deferred maintenance associated with many of these facilities and serve as a source of capital investment.
c. Tapping into a portion of the funds that have been made available through Measure HHH, the LA City general obligation bond to support permanent supportive housing for chronically homeless individuals, which city voters approved in November 2016;
d. Tapping into county funds raised Measure H, passed by county voters on the March 2017 ballot.

II. BACKGROUND

a. Residential Options for Persons Living with Mental Illness

People living with a serious mental illness account for less than six percent of the population[5]. With the shift away from state institutions that commenced in the last 1970's, and the lack of community-based treatment programs and facilities that were promised as an alternative, hundreds of thousands of individuals in the US suffering from mental illness have either been "reinstitutionalized" in prisons and jails, or are homeless. The remainder who have housing are primarily in one of three places:

- Living at home with family
- Living in permanent supportive housing as part of the "Housing First" movement to move people experiencing homelessness from the street into a living unit
- Living in privately operated "board and care" facilities.

In Los Angeles County, where the most recent point-in-time homeless count identified 57,794 homeless people, the number of people living with mental illness far exceeds the housing options available. The 2017 demographic survey conducted by the Los Angeles Homeless Authority (LAHSA) identified that 30 percent of the homeless population in Los Angeles County suffers from a serious mental illness. That would amount to approximately 15,728 people.

[4] "Disparities in Reimbursement Rates." Chart prepared by Barbara B. Wilson, LCSW, is attached as an Exhibit.
[5] Source: *Insane Consequences* by DJ Jaffee, referencing research conducted at the time SAMHSA's Center for Mental Health Services was created. The definition defines serious mental illness in adults as, "those mental illnesses that met the criteria of [latest edition of] DSM and ... resulted in functional impairment which substantially interferes with or limits one or more major life activities."

Further, the Los Angeles County jail is generally characterized as one of the largest mental institutions in the country, with over 4,700 inmates incarcerated suffering from mental illness.

With the expressed city/county goal to end chronic homelessness in LA County, which is a national objective as well, attention must be paid to all housing options available, or in the pipeline, to house people living with mental illness.

This report shines a light on the state of the board and care system in L.A. County, which represents a precious housing resource for people living with mental illness. The board and care system provides a residential setting for adults and provides supervision, support, protection and security in a group setting. The provider must be licensed by the Department of Health and Human Resources, Office of Health Facilities Licensure and Certification.

Last year, Los Angeles County managed to house over 14,000 people, a record amount and yet still ended up with an increase of 23% in its homeless population. Analysis points to many reasons with significant ones being the erosion of current affordable housing stock and issues of NIMBYism when it comes to the development of more affordable housing.

The board and care system is precariously resourced and prospects for the continued vitality of this system in the wake of shockingly low daily rental rates per resident ($35) is jeopardized. The failure of this system could exacerbate the homeless situation in LA County with residents exiting board and cares back into homelessness and/or board and care facilities no longer being available to accept new residents.

b. Types of Adult Residential Facilities (ARF's)

Adult Residential Facilities[6] are regulated by the Community Care Licensing Division (CCLD) of the State of California. The provisions are articulated in the Community Care Facilities Act of the Health and Safety Code. Typically, the services provided by an ARF include lodging, food service, care and supervision[7], assistance with taking medications in accordance with a physician's order, assistance with transportation to medical and dental appointments, planned activities, housekeeping, laundry service and maintenance or supervision of cash reserves.

The Community Care Licensing Division oversees several types of residential and day facilities (e.g., Residential Care Facilities for the Chronically Ill, or Residential Care Facilities for the Elderly, to name just two) but for the purposes of this report, we are focusing on what is typically referred to as a board and care, or ARF, in the vernacular of the state.

[6] An Adult Residential Facility means any facility of any capacity that provides 24-hour a day nonmedical care and supervision to the following: (A) persons 18 years of age through 59 years of age; and (B) persons 60 of age and older only in accordance with Section 85068.4 (Acceptance & Retention Limitations) [Source: Community Care Licensing Division (CCLD) report presented by Claire Matsushita, Asst. Program Administrator, to LA County Mental Health Commission on April 27, 2017.]

[7] "Care and Supervision" means those activities which, if provided, shall require the facility to be licensed. It involves assistance as needed with activities of daily living and the assumption of varying degrees of responsibility for the safety and well-being of the residents. [Source: CCLD report]

ARF's may serve people suffering from a mental illness, people with developmental disabilities or elderly residents. They generally do not provide skilled nursing services, with some exceptions.[8]Some facilities are exempted from the CCL licensing process, and there is anecdotal evidence that some formerly licensed board and care homes are shifting to the unlicensed domain. For example, a home or facility that supplies room and board only, with no elements of personal care, is not licensed. These facilities operated "under the radar" and are not subject to any type of regulatory oversight. Recovery houses for persons recovering from substance abuse are also not licensed. (See Appendix A.)

c. The Inventory

The challenge of this research has been to identify the trends with respect to available beds for persons suffering from mental illness. Anecdotal evidence suggests that board and care operators are closing down their facilities and selling their property *at an alarming rate.* While the department has kept track of board and care facilities that it has contracts with, this pool is small compared to all inventory. In meetings with DMH department staff in Q4 2017, we asked for:

- Trends over a two to five-year period documenting number of facilities closing and number of beds impacted.
- Breakdown of current inventory of housing for mentally ill as compared to elderly or intellectual disabilities.
- Information about all board and care facilities in the county, not just those with whom the county has an agreement.

As they say, you can't manage what you don't measure, so the lack of data is an impediment to any effort to stem the loss of more beds for this population.

DMH is in the process now of ramping up its efforts to track this information. This positive development is in part due to the internal resetting of priorities and emphasis under the new Director. We also believe that this invigorated effort is in part in response to this Ad Hoc Committee's work. The timing and request of the recent motion by the Board of Supervisors to track housing for a real time data base has also been a significant factor. In response to the Board Motion, DMH has assigned staff to move forward with soliciting and developing a resource manager and locator for 24hr services. They are currently doing a process improvement analysis to help determine what the scope and functionality of the application needs to be. They still will need to use that scope to find the best application for this need.

This process is not yet complete though and *we ask the Board to continue to expect, encourage and enable the department to gather this information.*

[8] According to the CMHPC report, "Residential care facilities are not allowed to provide skilled nursing services, such as give injections nor maintain catheters nor perform colostomy care (unless there is a credentialed RN or LVN individual working in the home), but they can provide assistance with all daily living activities, such as bathing, dressing, toileting, urinary or bowel incontinency care." P. 3.

The Mental Health Commission organized presentations on this topic at the April 27, 2017 general commission meeting. At that time, which is still the most current data we have, **CCLD reported that in Los Angeles County there are 1,283 Adult Residential Facilities with a bed capacity of 11,979.**

What we have not been able to determine is the breakdown of population served by these facilities. At a minimum, these would be important data points to track:

- Current number of facilities serving people suffering from mental illness. Number of beds and ***how this has changed over time.***
- Current number of facilities serving people living with intellectual disabilities and change over time.
- Current number of facilities serving adult elderly or other needs and change over time.

Absent this data, it is impossible to provide a snapshot of trends. Anecdotal evidence, however, suggests that there is an erosion of bed availability for persons with mental illness due to either closure of facilities for economic reasons, shift to an unlicensed facility[9] or conversion to serve a population where the reimbursement rate is higher. This anecdotal trend also begs the question: are there any new facilities coming on line to add beds to a system that appears to be stressed? If not, what is the reason for lack of entry into this market?

Further, it would be important to know how many *unlicensed* board and care facilities in the county serve persons with mental illness. An unlicensed facility will sometimes recruit residents from licensed facilities by promising them the ability to retain more of their monthly disability check. These facilities will vary wildly in quality and in the degree of services provided. Over the years DMH has had many conversations with County Counsel and the Auditor-Controller about unlicensed facilities. They have raised some concerns including monitoring and quality of care issues. And yet, we know that many of our residents are living in these facilities. We do not know how many of these facilities would be willing to become licensed if certain impediments were removed, education and training of what it would entail to be licensed were provided or incentives were offered.

d. Trends

Concern about the relative fiscal health of the board and care system is not unique to Los Angeles County. In 2016, the CA Mental Health Planning Council initiated a statewide review of Residential Care Facilities in the state. They surveyed all 58 counties in CA, and 22 responded. (Los Angeles county was not one of the respondents.) The counties responded that 907 beds were needed, and 783 were lost over the past several years.[10] The respondents also indicated that in approximately 15 counties, beds had to be sought in another county because of the deficit in the home county.

According to the Planning Council, in their 2017 report, there were three main reasons why the shortage persists: (1) Financial; (2) Community Opposition, and (3) Staffing. Their data relative to the financial realities associated with running an adult residential facility will be described in greater detail below.

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[9] It has been suggested that some licensed facilities are converting to unlicensed status. Such a facility may recruit residents from licensed facilities by promising them the ability to retain more of their monthly disability check. However, less services are provided. It is hard to obtain details about specific locations, as these facilities prefer to remain "off radar."

[10] Source: CMHPC October 2017 report; page. 5.

Another entity, the California Association of Local Behavioral Health Boards & Commissions, published an issue brief on ARF's in October, 2017 which outlined concerns about the "revolving door" when there are limited options for people coming out of acute in-patient treatment programs, transitional living or the correctional system.

In Los Angeles County, we assert that we are facing a crisis with respect to the survival of these precious housing resources. In just the past year, this ad-hoc commission received word that 11 board and care homes, ranging from 6 to 100+ beds, have closed, converted their operations or are considering closing. **This is just a small sample, pulled from our own network.** Examples of recent closures include:

- Brentwood Manor. This facility, located at 1449 Wellesley Avenue in Los Angeles was purchased in March, 2017 by a developer with the intention to transform it into a boutique hotel
- Western Ferndale Board and Care located at 1745 N. Western Avenue in Los Angeles
- Villa Poinsettia, 823 N. Poinsettia Pl, Los Angeles

These are facilities who have expressed concerns about their ability to continue their operations under the current scenario:

- Sunland Manor (approximately 100 beds), 10540 Sherman Grove Avenue, Sunland CA.
- Sepulveda Residential (approximately 80 beds). 8025 Sepulveda Blvd, Van Nuys, CA.
- Sharp Board & Care (6 beds), 10537 Sharp Avenue, Arleta, CA.
- Amigo Board & Care (two homes at 6 beds each), 8238 Amigo Avenue, Reseda and 23601 Vanowen, West Hills, CA.
- Blake Family Home (6 beds), 606 Jackman Street, Sylmar, CA.
- Alma Lodge (80 beds), 1750 Colorado Blvd, Eagle Rock, CA.
- Hartsook Board & Care (16 beds), 11045 Hartsook, North Hollywood, CA
- Golden State Lodge (14 beds), 11465 Gladstone Way, Lakeview Terrace, CA

Many of these have been in these neighborhoods for years. Owners who have run these businesses as family operations are now finding that the land is worth more that the business itself and are choosing to sell to developers. Not only are beds lost but opposition to opening other facilities in some of these communities proves insurmountable due to both the NIMBY mentality, changes in zoning and increased land and construction costs. Current board and care inventory ends up being used to re-house these displaced residents, further limiting options for homeless or new clients.

e. Financial Realities

With a reimbursement or rental rate of $35/day [11], a board and care operator is hard pressed to meet their obligations to provide the full array of services required under their licensing arrangement, with no relief in sight.

Further, the $134 that remains for the resident (from their social security disability check) must cover all their discretionary expenses including: clothing, transportation and travel, entertainment, cigarettes, and miscellaneous life expenses. This amounts to about $4 a day – a challenging amount for anyone to

[11] As of January 1, 2018, the rates have changed ever so slightly. SSI rates for clients are $1037 plus $20 if they receive disability. Personal spending for incidentals is $134.

consider. This explains why residents of board and care homes, who don't have access to supplemental funding from family or friends, may resort to panhandling to make ends meet.

DMH has initiated two strategies for addressing the financial viability and program needs of Board & Care facilities.

1) Under Whole Person Care DMH is currently amending contracts with existing Community Care Residential Facilities for a $25 per day patch for clients that have been determined to have higher needs.

2) In addition, DMH will be releasing a Request for Applications (RFA) Specialized Supplemental Care Program (SSCP) in the spring 2018 to offer funding for augmented supports to all licensed adult residential facilities across the county. The RFA will allow DMH to augment the Basic Rate to fund additional staffing needed to serve individuals that have a serious mental illness and, due to their level of functioning, symptoms, and psychiatric history, require service interventions that are in addition to or often more time-intensive to deliver than Basic Services. The payment of a supplemental rate will enable more placement options to individuals waiting to be transitioned from a higher level of care to the most appropriate residential setting based on their ability to function independently. The supplemental rate programs correspond to the level of service and/or staff. Funding will be offered for two different tiers of service: $25/day and $40/day.

Neither of these strategies has been fully implemented. And, as presented below, it is not clear that it will be enough. That is why it is essential that other community partners join in this effort.

The CA Mental Health Planning Council, in their October 2017 report presented a sample budget for a 13-resident facility. It documents in stark terms that the "rent" paid by residents does not even come close to covering the basic aspects of staffing, services and the facility costs. A break-even rent for this facility would require $2,805 per month. This budget is included as Table 1.

Table 1

Residential Care Facility Sample Annual Budget (13 Person)

Title	Amount	Comment
REVENUE		
Resident Fees	$160,056	$1026/month for 13 residents at 95% occupancy
Total Revenue	**$160,056**	
EXPENSES		
a. Personnel Expenses		
Line Staff	$182,000	4.5 Staff at $15/hour covers single coverage 7 days/week. Plus 1 FTE at 40 hours/week for administration/transport of clients to doctors, admissions, grocery shopping, etc.at $20/hr.
Landscaping	$2400	$200/month
Relief Staff	$15,600	Fill-in for sick/vacation employees at 20 hours/week
Subtotal	$200,000	Presumes 9 sick days, 14 vacation days, 8 holidays/employee/year
b. Salary Related Expenses		
Health/Dental/Life/Vision Insurance (HSA)	$39,600	$600 month/employee, prorated for part-time for 5.5 employees. Rate is for minimal insurance.
Unemployment Insurance	$1,482	
Worker's Compensation Insurance	$13,836	

FICA/Medicare	$15,116	
Subtotal	$70,034	
c. Other		
Training	$2000	
Total Other Expenses	$2000	
Total Personnel Expenses	**$272,034**	
d. Operating Expenses		
Legal and Other Consultation	$1000	
Household Supplies	$10,000	Cleaning, paper supplies, non-food, any recreational supplies, linens, towels, paper goods
Office Supplies	$2,250	
Computer/Office Furnishings	$1000	
Utilities	$20,238	
Maintenance – Building and Equipment	$12,000	Presumes that this includes furniture and appliance replacement
Vehicle Maintenance	$6,000	Presume one vehicle for use at $550/month
Food	$40,880	$8 person/day plus one staff eating
Insurance	$8,215	
Telephone/Internet/Cable	$3000	
Printing and Postage	500	
Licensing and Permits	$1,711	
Property Taxes	$6,000	Presumes property purchased for $600,000 with $100,000 down payment
Advertising	500	
Total Operating Expenses	$113,294	
Rent or Loan Payments	$30,396	$500,000 loan for 30 years at 4.5%
Total Expenses	$415,724	
Total Net Income (Loss)	**(255,668)**	(Revenue $160,056 minus Cost $415,724 = Loss $255,668)

Source: CA Mental Health Planning Council, October 2017 report, page 9.

f. Case Studies

1. Golden State Lodge

In an example close to home, The Golden State Lodge, which has announced its intention to close, created a simple spreadsheet to document the fiscal strain that makes it impossible to operate without some additional source of funds. In this scenario, the assumptions are predicated upon a census that ranges between 10 to 13 guests per month. ***A break-even scenario would require a monthly rent of $2,500 per person.*** The full budget is included as Appendix C, but this abridged analysis documents the dilemma.

Table 2
Golden State Lodge 2017 budget

Category	Amount	Total
Revenue		
Resident rent	$ 122,100	
Total revenue		$ 122,100
Expenses		
Administration		
Payroll	$ 123,954	
Payroll taxes	$ 1,399	
Workers comp	$ 11,515	
Liability insurance	$ 9,757	
Property insurance	$ 9,900	
Employee insurance	$ 15,400	
Property taxes	$ 17,600	
Amortization	$ 41,800	
Continuing education	$ 2,200	
Total admin		$ 233,525
Operations		
Food	$ 19,500	
Utilities	$ 19,393	
Repairs/mtce.	$ 10,700	
Laundry	$ 2,750	
Housekeeping	$ 3,300	
Misc	$ 7,700	
Total operations		$ 63,343
Total		$ 296,868
Profit/Loss		$ (174,768)

2. Villa Stanley

At the April 27, 2017 hearing of the County Mental Health Commission on the topic of the board and care system, Dr. Jay Plotzker, Administrator for two facilities, presented specific information about the costs of running the two facilities, the demographics of the residents and the needs. (See Appendix B.)

His company runs two ARF's. Villa Stanley, licensed as an ARF in 1989, has 80 beds and is for non-ambulatory mentally ill clients. Villa Stanley East, licensed in 1999, has 62 beds. Residents are referred to Villa Stanley through social work personnel at area hospitals, families, social service agencies or DMH district offices.

Table 3
Villa Stanley Census

Tenure of Residents	Five years or more[12]	50%
	One to five years	30%
	Less than one year	20%
Gender	Male	80%
	Female	20%
Ethnicity	Caucasian	60%
	Hispanic	10%
	African American	22%
	Asian	8%
Age	18 – 35 years	20%
	35 – 60 years	60%
	60 and above	20%
Benefits	MediCal and SSI only	60%
	Medi-Medi SSI and SSA	25%
	VA	15%
Ongoing Therapy	Medi-Medi w/ PHP access	7%
	Veterans w/ MHICM or DDTP	5%
	FSP or Inter. Funding/DMH	15%
	No ongoing therapy	70%

In his testimony to the Commission, Dr. Plotzger outlined the demands placed upon the facilities. His prime concern is financial. In his words: "The board and care is paid for all its services a total (SSI basic rate) of $1,026.37 per month. That works out to $33.74 per day. That is an absurd amount given all that we provide to care, support and assist clients."

Dr. Plotzger provided the Commission with some insight into the service demands placed upon the board and care operator. With respect to client care, they have to tend to their financial issues in resolving SSA, VA or family-related payments.

They must also tend to their client's mental health needs – emergency and routine – even for those who have no ongoing relationship with a service provider. Because no more than 30 percent of the residents are receiving therapy at any given time, there is a tremendous need for the remainder to have access to case managers, doctors, clinical therapists.

There is a lack of access to educational, vocational or life-skills education. Particularly for younger residents, who might have an opportunity to wean themselves off government support, there is no support for vocational training. They must tend to the routine and emergency maintenance needs of

[12] According to Dr. Plotzker, some have lived at Villa Stanley for up to 20 years.

their facilities and be responsive to licensing requirements. They also have to stay connected with the community, to address the issues that typically come up in the neighborhood.

The reimbursement does not keep up with inflation. For example, he reports, the cumulative Consumer Price Index (CPI) for the LA area, since 2010, was 11.4%. Since 2010, the cumulative SSI/SSP increase has been only 6.4%. He suggested that with even a $5 or $10 per resident, per day increase, "there is much that we can do."

The future financial picture looks bleak. He expressed concern about the mandated increased in the minimum wage, and how that will impact their ability to comply with mandatory staffing of an ARF, as per Community Care Licensing guidelines. He anticipates increases in the cost of food, and related staffing costs related to preparation. He foresees increasing insurance costs (liability and medical) as well as Worker's Compensation. And finally, there is the ongoing costs associated with building repairs and maintenance. His facilities (as is the case with many others in the county) are aging and there are limited funds to handle capital improvements. He cited an example whereby two years ago, he had to pay $50,000 to replace an elevator.

In sum, if this system were funded more adequately, he suggested that the clients would have access to more therapy and services, activities, better food and nicer surroundings.

g. Quality of Facilities

This Ad-Hoc committee has limited its focus, for the most part to the financial issues facing board and care facilities and the critical need to stop the loss of these types of beds. There remains a real issue about the quality of life of those who live at facilities. Many of these facilities are run down and have multiple deferred maintenance needs. Owners will say that the money doesn't exist for them to do needed repairs, much less improve the cosmetic appearance of these facilities.

Financial pressures prevent most of these facilities from also providing any type of programming, therapeutic or otherwise. Many residents spend their days with little to do. Ironically, DMH and facilities have had to be careful in what they offer because of concerns of triggering the Federal IMD Exclusion. The exclusion prohibits Federal Financial Participation funds from being drawn down for mental health services if an owner of a facility is also the service provider on the site. That being said, DMH has developed some innovative programs such as the enriched residential facilities that enable providers to comply with regulations while offering treatment to clients, albeit at a nearby clinic site. We would argue that more can be done in this realm and hope that it will remain a topic of concern and focus.

III. CALL TO ACTION

First, it is important the county make a commitment to data collection to understand the trends relative to beds available for people with mental illness. The housing shortage is at a crisis level in L.A. County, and it is important to track this inventory to understand gaps and needs. The data collection, at the very least should:

- Identify the current inventory of ARF beds available for people living with serious mental illness today, and compare, to the extent possible, how the inventory has changed over the last one to five years;

- Identify the extent to which beds lost over the last one to five years have disappeared due to:
    - Conversion to another demographic group which offers greater subsidy
    - Conversion to unlicensed status
    - Sale of property for another use
    - Closure of home
- Identify if any new facilities have come on line in the last one to five years

Second, a sustainable commitment to enhanced funding needs to be identified to forestall additional shutdowns and to enhance quality of life for individuals living in these homes. It is estimated that "patches" or subsidies ranging from $64/day to $125/day (according to the CMHPC) would be necessary to maintain fiscal viability.[13] This will require more than just what is currently proposed for patches by DMH and other community partners must step in. The county should conduct an audit of ARF's of various sizes to ascertain what the extent of that patch would be in L.A. County to protect this housing inventory.

Third, it is recommended that policy makers who analyze housing supply and demand in Los Angeles County include Adult Residential Facilities in the continuum of community-based housing available for people with serious mental illness, as well as formerly homeless individuals. Arguably, formerly homeless residents with serious mental illness are more vulnerable than those targeted for permanent supportive housing with services attached. Surprisingly, under federal rules for defining "chronic homelessness," people leaving institutions are often not considered eligible for permanent supportive housing.

Fourth, in addition to shoring up the financial viability of board and care homes, it is critical to look beyond just the "brick and mortar" sustainability of these facilities and aspire to investing in opportunities for an enhance quality of life for those who live within this system. Patches above and beyond what is necessary to mitigate against closure will be required to invest in critical human needs including transportation of residents, linkage to day-time services and activities, and training for staff. Enrichment opportunities may also be generated by linkages to community services, adult schools, churches and volunteers, and this will require staffing and coordination.

Fifth, the Department of Mental Health should commit to a formalized liaison relationship with the board and care operators in order to provide support, training and an opportunity to dialogue about needs and aspirations.

Sixth, the county should identify a liaison with the California Mental Health Planning Council who has embraced this issue as a critical priority. The CMHPC has identified some state-level solutions that may require county policy support. Included in those recommendations is consideration for a "tiered level of care system" which would allow for different levels of reimbursement based upon resident needs (similar to what is done for residents with developmental disabilities.) The Planning Council has also recommended advocating for a higher State Supplemental Payment (SSP) rate.

[13] This recommendation is echoed by the CA Assoc. of Local Behavioral Health Board & Commission's report that indicates a patch of $64 to $125/day is needed to sustain operations for facilities >45 beds.

State of California
Health and Human Services Agency
Department of Social Services

Community Care Licensing Division (CCLD)

Claire Matsushita, Assistant Program Administrator
Benita Yates, Regional Manager
Adult and Senior Care Program

Mission of CCLD

- To promote the health, safety, and quality of life of each person in community care through the administration of an effective collaborative regulatory enforcement system.

CCLD Responsibilities

- License community care facilities that serve children, adults, and older adults
- Routine facility inspections
- Complaint investigation
- Consultation to facilities on how to maintain compliance

3

Adult and Senior Care Facilities

- Adult Day Programs (*ADP*)
- **Adult Residential Facilities (*ARF*)**
- Residential Care Facilities for the Chronically Ill (*RCF-CI*)
- Social Rehabilitation Facilities (*SRF*)
- Adult Residential Facilities for Persons with Special Health Needs (ARFPSHN)
- Enhanced Behavioral Support Home (EBSH)
- Crisis Community Home (CCH)
- **Residential Care Facilities for the Elderly (RCFE)**

4

Number of Facilities in Los Angeles County

- ARFs - 1283 with bed capacity of 11,979
- RCFEs – 1343 with bed capacity of 33,911

- As of 4/3/2017

5

Adult Residential Facility (ARF)

- "**Adult Residential Facility**" means any facility of any capacity that provides 24-hour-a-day nonmedical care and supervision to the following:
  - (A) persons 18 years of age through 59 years of age; and
  - (B) persons 60 years of age and older only in accordance with Section 85068.4 (Acceptance & Retention Limitations)

6

Adult Residential Facility (ARF)

Community Care Facilities Act
Health & Safety Code

General Regulations

Title 22, Div. 6, Chap 1, Art 1-2 - General Licensing Requirements	80000-80012
Title 22, Div. 6, Chap 1, Art 3-4 - General Licensing Requirements	80017-80046
Title 22, Div. 6, Chap 1, Art 5-6 - General Licensing Requirements	80051-80079
Title 22, Div. 6, Chap 1, Art 7-8 - General Licensing Requirements	80086-80095

ARF Regulations
Sections 85000-85091.4

7

Residential Care Facility for the Elderly (RCFE)

- means a housing arrangement chosen voluntarily by the resident, the resident's guardian, conservator or other responsible person; where 75 percent of the residents are 60 years of age or older and where varying levels of care and supervision are provided, as agreed to at time of admission or as determined necessary at subsequent times of reappraisal.

8

Residential Care Facility for the Elderly (RCFE)

Residential Care Facilities for the Elderly Act
Health and Safety Code
1569 through 1569.889

RCFE Regulations

Title 22, Div. 6, Chap 8, Art 1-3(Cont.) - RCFE	87100-87163
Title 22, Div. 6, Chap 8, Art 3(Cont.)-6(Cont.) - RCFE	87163-87356
Title 22, Div. 6, Chap 8, Art 6(Cont.)-9(Cont.) - RCFE	87356-87508
Title 22, Div. 6, Chap 8, Art 9(Cont.)-15 - RCFE	87508-87793

9

Services Provided at Facilities

- Lodging
- Food Services
- Care and Supervision
- Assistance with taking medications in accordance with the physician's order
- Assistance with transportation to medical & dental appointments
- Planned Activities
- Housekeeping
- Laundry Service
- Maintenance or supervision of resident cash resources

10

What is Care & Supervision?

- "Care and Supervision" means those activities which if provided shall require the facility to be licensed. It involves assistance as needed with activities of daily living and the assumption of varying degrees of responsibility for the safety and well-being of residents.

11

What are Activities of Daily Living?

- Assistance in dressing, grooming, bathing and other personal hygiene
- Assistance with taking medication
- Central storing and distribution of medications
- Arrangement of and assistance with medical and dental care. This may include transportation
- Maintenance of house rules for the protection of residents
- Supervision of resident schedules and activities
- Maintenance and supervision of resident monies or property
- Monitoring food intake or special diets

12

Exempt Facilities from CCL Licensure

Exempt facilities	Example
Health Facility	*Acute Hospital*
Clinic	Medical Clinic
Homeless Shelter	*Union Rescue Mission*
House, institution, hotel, that supplies board & room only, or room only, or board; no elements of care	Boarding House
Recovery houses for persons recovering from alcoholism or drug addiction; no care or supervision provided	*Sober Living Facilities*
Adult alcoholism or drug abuse recovery or treatment facilities*	Treatment facilities licensed by Dept. Of Alcohol & Drug Programs
Care & Supervision provided by a close friend-friendship pre-existed a provider/recipient relationship	*A family home*
Facilities conducted by well recognized church –treatment depends on prayers and spiritual means	Christian Scientist Facilities

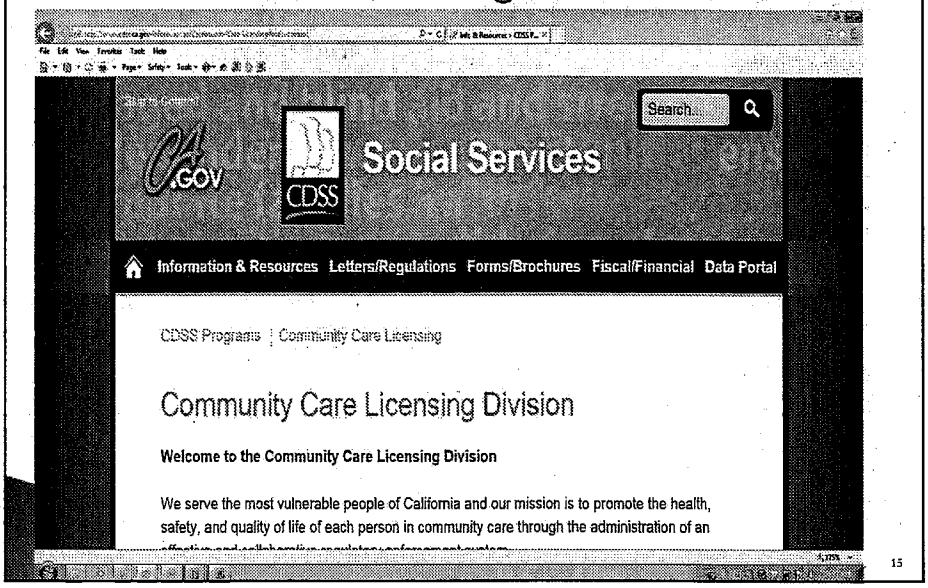
13

CCLD Complaint Process

- **Centralized Complaint Information Bureau (CCIB) – write-up complaint when there are allegations of regulatory or statutory violations.**
- **Mandate – unannounced site visit within 10 calendar days.**
- **If required, cross report to local law enforcement, DPH, DHCS.**
- **If needed, contact other agencies (i.e. code, fire, APS, LTCO).**

14

CCLD Homepage
ccld.ca.gov



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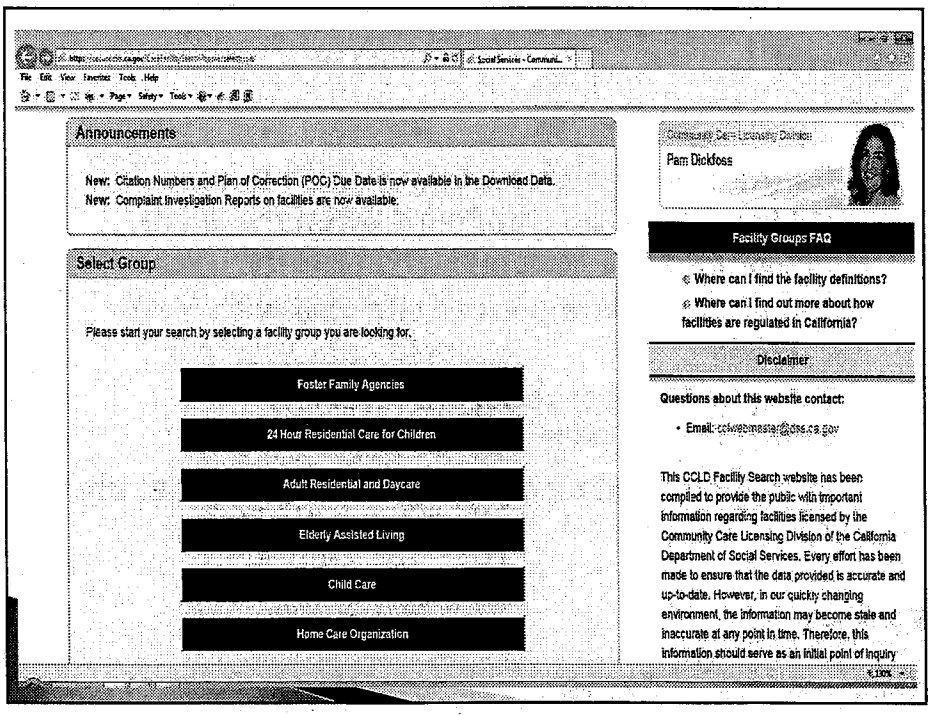


335 N. Stanley Ave.
Los Angeles, CA 90036

License # 198601211

Villa Stanley

ADULT RESIDENTIAL FACILITY

Tel: (323) 937-4856 **Fax:** (323) 937-5035

Memo

Date: May 4, 2017

To: Caroline Kelly

From: Dr. Jay Plotzker – Administrator

RE: Notes for 4/27/2017 MHC meeting

SUMMARY

- Villa Stanley – 80 Beds – non-ambul. – MI clients
- Villa Stanley East – 62 Beds - " "

VS – Licensed as ARF in 1989

VSE - licensed as ARF in 1999

- Mission - To provide a safe, dignified, caring and supportive living environment for adults who suffer from a chronic mental illness. We provide non-medical care, supervision and assistance through the administration of timely service and regulatory compliance.

- Our population referred – social work personnel at area hospitals; families; social service agencies or DMH district offices.

- 50% - residents for 5 yrs. or more (some for up to 20 years)
- 30% - residents for 1-5 years
- 20% - residents under 1 year

- 80% - Men
- 20% - women

- 60% - White
- 10% - Hispanic
- 22% - African American
- 8% - Asian

- 20% - 18 – 35 years old
- 60% - 35 – 60 years old
- 20% - 60 and above

- 60% - MediCal and SSI only
- 25% - Medi-Medi – SSI and SSA
- 15% - VA

Receiving Ongoing Therapy

- 7% - Medi-Medi with PHP access
- 5% - Veterans with MHICM or DDTP program
- 15% - FSP or Inter. Funding/DMH assigned or with e.g. Didi Hirsch, etc.

  Thus, a total of no more than 30% receive regular therapy.

Need for Board and Care

- Reduce homelessness
- Unburden area hospitals and MediCal budget necessary to pay for such service
- Provide quality living environment
- As per the data from CCL, too many beds are not being replaced in ARFs. (I was just told today that Harbor View in Long Beach is being closed and sold for commercial/residential development).

What is on our plate to administer?

- Daily facility and building maintenance issues

- Resident finance issues – SSA; VA; family
- Client mental health issues – emergency or not
- Regulatory concerns
- Routine business-related matters
- Neighborhood issues – residential and commercial

Major Concerns

- MONEY – for what?
- No more than 30% of residents are receiving ongoing therapy – We need to be able to increase that percentage drastically. However, there is no funding available. We need a team to support every resident – doctors, administrators, case mgrs., therapists, etc.
- No vocational training or continued education is available. They need an opportunity, especially the younger ones, to prepare for a life, not totally dependent on gov't. support.
- The board and care is paid for all its services a total (SSI basic rate) of $1,026.37 per month. That works out to $33.74 per day. That is an absurd amount given all that we provide to care, support and assist clients.
- We are not even keeping up with inflation.
  a) Since 2010 the cumulative CPI (Consumer Price Index) for L.A. is 11.4%
  b) While, since 2010 the cumulative SSI/SSP increase has only been 6.4%
  c) Thus, we are already 5% behind. And that doesn't mean that we were being funded adequately to begin with.
  d) Even with a modest increase of $5.00-$10.00 per day per resident there is much we can do. We know how to make dollars stretch and get the biggest bang for the buck.

The issues that we face are not getting easier.

- Recent and further mandated minimum wage increases – and how that impacts the cost of properly staffing an ARF as per CCL guidelines.
- Cost of food and preparation.
- Increasing cost of insurance (liability and medical) as well as Workers Comp.
- The ever increasing cost of building repairs and maintenance especially as these facilities age. (2 years ago it cost me nearly $50,000 to update and replace our elevator – these buildings are old).

What would we do with some extra funds?

- More therapy
- More and Better activities
- More and Better food
- Nicer surroundings
- More services

To whatever extent the commission is able to influence the legislature, the governor, or any agency involved in the budget allocation process – it would be most appreciated by owners, staff, clients, residents and the larger L.A. community if you could see to it that the mentally ill are helped and subsidized just a bit more thorough the significant and vital Board and Care system.

Appendix C: Golden State Board and Care Proposed Budget Plan 2017

Month	Jan	Feb	Mar	Apr	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Census	10	12	13	13	12	11	12	12	12	12	12	
Revenue	$11,000	$13,200	$14,300	$14,300	$13,200	$12,100	$13,200	$13,200	$13,200	$13,200	$13,200	$122,100
Administrative cost												
Payroll	$10,852.87	$10,852.87	$10,852.87	$10,852.87	$10,852.87	$10,852.87	$13,938.07	$13,938.07	$13,938.07	$13,938.07	$13,938.07	$123,954.70
Payroll taxes	$1,089	$1,089	$1,089	$1,089	$1,089	$1,089	$1,399	$1,399	$1,399	$1,399	$1,399	$1,399
Workers comp	$980	$980	$980	$980	$980	$980	$1,127	$1,127	$1,127	$1,127	$1,127	11515
insurance liability	$887	$887	$887	$887	$887	$887	$887	$887	$887	$887	$887	9757
Insurance property	$900	$900	$900	$900	$900	$900	$900	$900	$900	$900	$900	9900
Insurance employee	$1,400	$1,400	$1,400	$1,400	$1,400	$1,400	$1,400	$1,400	$1,400	$1,400	$1,400	15400
property taxes	$1,600	$1,600	$1,600	$1,600	$1,600	$1,600	$1,600	$1,600	$1,600	$1,600	$1,600	17600
amortization	$3,800	$3,800	$3,800	$3,800	$3,800	$3,800	$3,800	$3,800	$3,800	$3,800	$3,800	41800
continuing education	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	2200
Operation												0
Food	$1,500.00	$1,800	$1,800	$1,950	$1,800	$1,650	$1,800	$1,800	$1,800	$1,800	$1,800	$19,500.00
utilities	$1,763	$1,763	$1,763	$1,763	$1,763	$1,763	$1,763	$1,763	$1,763	$1,763	$1,763	19393
repairs and Maintenance	$450	$450	$750	$3,000	$200	$1,500	$450	$450	$450	$1,500	$1,500	$10,700
Laundry	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	$250	2750
House keeping	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300	3300
Miscellaneous	$700	$700	$700	$700	$700	$700	$700	$700	$700	$700	$700	7700
	$26,671.87	$26,971.87	$27,271.87	$29,671.87	$26,721.87	$27,871.87	$30,514.07	$30,514.07	$30,514.07	$31,564.07	$31,564.07	$296,868.70
LOSSES	$15,671.87	$13,771.87	$12,971.87	$15,371.87	$13,521.87	$15,771.87	$17,314.07	$17,314.07	$17,314.07	$18,364.07	$18,364.07	$174,768.70

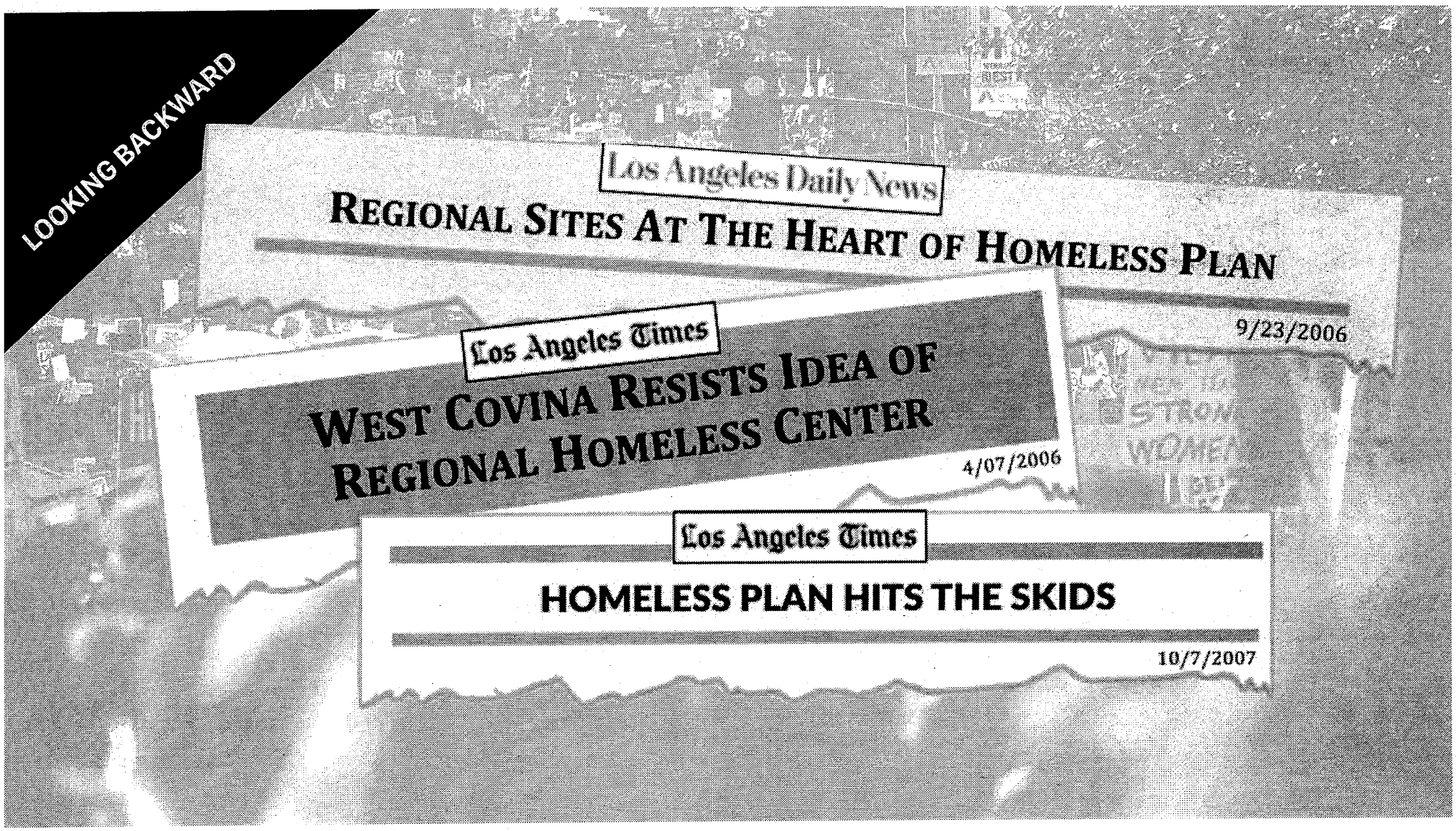
est revenue at 2500 per person = 360,000

revenue per yeat	122,100
Expenses per year	-296,868.70
	174768.7

note : The Nurse Consultant and the administrator is not included in the payroll and insurance

DISPARITIES IN REIMBURSEMENT RATES -- prepared by Barbara B. Wilson, LCSW, 2016				
Facility	Definition	Requirements	Population Served	Reimbursement Rate
Adult Residential Facilites (ARF)				
Licensed by State Dept Community Care under Title XXII of the Welfare & Institutions Codes	9/6/2016	*Includes but not limited to:* •3 meals/day & snacks •Clean living spaces •Limit 2 people per room •No walk-through bedrooms •Must have fire clearance •Must have proof of insurances •Must maintain records on resident & state approved forms •Notify licensing of any "special incidents" affecting the status of a resident.	Intellectually Disabled (Regional Center)	$85-$150/day. 5% raise approval effective 7/1/16.
			Mentally Disabled (DMH)	Mentally ill- $35/day
Residential Care Facilities for the Elderly (RCFE) - *similar to ARF*				
			Age 60+	Begin at $2000/mo for shared rooms.
Assisted Living Facilities				
Licensed by state using ARF and/or RCFE license				Based on a 2-part structure of rent for the space (shared studio/larger apartment up to 2 bedrooms.) Base rent usually begins $2500 up *plus* services charged separately. *Example*: Medications administered. Residents are charged separately for each time they are presented meds (more money for 3x day vs. daily). Laundry/housekeeping services etc, are charged separately as well as meal plans, typically. So the actual dollar amount each month varies but is typically $5-8K.
Sober Living Facility				
This type of housing has no regulation by any agency or professional agency.				Rates vary from $100/week to whatever the market will bear. Residents typically reside in bunk beds, 4-6 beds per bedroom but might also reside in the garage. In order to avoid being in violation w/state licensing, most of these facilities do not provide meals or medication supervision. Staff is often a person who has sobriety but may have observable psychiatric problems that are untreated. Fear is the common factor in many of these SLFs since one can be abruptly kicked out early in morning w/o notice or a place to go. Many of the "lower end" SLFs accept residents on GR & food stamps. Often resident is required to utilize their food stamps as part of the rent. Turnover of residents can be very high. Problems between residents over food are another issue. Most importantly, community home owner groups in R-1 zones are organizing to refue any kind of "mental" facilities to be permitted in R1 zones. This
Adult Day Care Programs				
Typically licensed.		Provides transportation, one meal and snacks. Typically operates a partial day, perhaps 9am-2pm. Nurse on duty, especially helpful for clients requiring injections such as insulin.		??
Intensive Outpatient Programs (IOP)				
Typically licensed.		Provides transportation, one meal and snacks. Typically operates a partial day, perhaps 9am-2pm. Psychiatric treatment including individual therapy & group therapy available. RN on duty as well.	Not usually available to Medi-Cal only insurance recipients.	?
Institution for Mental Disease (IMD)				
Set by CA State Dept of State Hospitals	"Secure" AKA locked facility.		Residents normally required to have some sort of legal hold placed on them in order to be considered: penal hold or a LPS conservatorship.	$178.24
Motels				
Motel 6, Sylmar	$59/night			


UNITED WAY
EVERYONE IN BRIEFING
THE WORK BEGINS NOW.
United Way
GREATER LOS ANGELES
LIVE UNITED


LOOKING BACKWARD
Los Angeles Daily News
REGIONAL SITES AT THE HEART OF HOMELESS PLAN
9/23/2006
Los Angeles Times
WEST COVINA RESISTS IDEA OF REGIONAL HOMELESS CENTER
4/07/2006
Los Angeles Times
HOMELESS PLAN HITS THE SKIDS
10/7/2007